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In the Supreme Court of the United States

OCTOBER TERM, 1984

JAMES P. KARTELL, HERBERT W. HORNE, JR.
AND HARRY D. WILSON, JR.,
PETITIONERS,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,
RESPONDENT.

Petition for Writ of Certiorari to the United States Court of Appeals for the First Circuit

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JAMES VANR. SPRINGER
(Counsel of Record)
RONALD K. PERKOWSKI
DICKSTEIN, SHAPIRO & MORIN
2101 L Street, N.W.
Washington, D.C. 20037
(202) 785-9700

STANLEY V. RAGALEVSKY
WARNER & STACKPOLE
28 State Street
Boston, Massachusetts 02109
(617) 725-1400

Attorneys for Petitioners

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Question Presented.

Whether the Court of Appeals correctly held that provider contracts by which a market-dominant health insurer imposes a maximum fee schedule upon physicians are categorically lawful under Sherman Act § 1, without evaluation under the rule of reason and notwithstanding the District Court's undisturbed findings, after trial, that the contracts unreasonably restrain competition in the relevant geographic market for physicians' services.

Parties to the Proceeding.

The petitioners named in the caption (Drs. Kartell, Horne and Wilson) are three of the four original plaintiffs; the fourth withdrew during the trial court proceedings. Dr. Grant V. Rodkey, Dr. Henry Brown and the Massachusetts Medical Society intervened as additional plaintiffs represented by separate counsel.* In addition to the respondent named in the caption (Blue Shield of Massachusetts, Inc.), Blue Cross of Massachusetts, Inc. was a defendant and the Massachusetts Commissioner of Insurance intervened as a defendant; both were dismissed from the action by the District Court (see A. 72) but the Massachusetts Commissioner of Insurance was nonetheless permitted to participate in the Court of Appeals as an appellant.

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* These "intervenor-plaintiffs" are filing a separate petition for a writ of certiorari.

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Petition for Writ of Certiorari to the United States Court of Appeals for the First Circuit

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James P. Kartell, Herbert W. Horne, Jr., and Harry D. Wilson, Jr. (plaintiffs below) petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the First Circuit entered on November 28, 1984, reversing the injunction in their favor entered by the United States District Court for the District of Massachusetts following a non-jury trial.

Opinions Below.

The opinion of the Court of Appeals (A. 1-A. 27) is reported at 749 F.2d 922. The opinion of the District Court (A. 28-A.

68), which includes its findings of fact and conclusions of law, is reported at 582 F. Supp. 734.

Jurisdiction.

The judgment of the Court of Appeals (A. 69-A. 70) was entered on November 28, 1984. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254 (1).

Statute Involved.

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

Statement of the Case.

Petitioners are physicians engaged in private practice in the Commonwealth of Massachusetts. Respondent Blue Shield is the dominant private insurer of physicians' services in Massachusetts; its subscribers amount to approximately 56 percent of the total population and 74 percent of the privately insured population (A. 40).[1] With limited exceptions, Blue Shield covers only services by physicians who have entered into its standard-form Participating Physician's Agreement, which includes the maximum fee terms challenged in this action (A. 34).[2] The result is that — as the District Court con-

[1] As noted *infra*, the Court of Appeals did not set aside any of the District Court's findings. Accordingly, the factual statements herein are supported by references to the District Court's findings. All references to "Blue Shield" are to respondent Blue Shield of Massachusetts, which serves the entire state.

[2] The District Court determined at an earlier stage of the case that this refusal to deal with "nonparticipating physicians" was mandated by Massachusetts law and therefore not subject to anti-

cluded in findings undisturbed by the Court of Appeals — "Massachusetts physicians have absolutely no meaningful economic choice except to agree to the pricing terms unilaterally established by [Blue Shield]" (A. 54). Over 99 percent of them have in fact so contracted (*id.*).

The Participating Physician's Agreement provides, with limited exceptions, that Blue Shield's insurance payment shall be the physician's sole compensation for a covered service, precluding any additional payment from his patient (A. 35). In other words, "balance billing" of patients is contractually prohibited. Moreover, as the Court of Appeals acknowledged, the method by which Blue Shield determines the amount of its insurance payment "has evolved, through the use of various 'capping' devices, towards payment of a 'fixed fee,' determined by Blue Shield, for each particular type of service" (A. 4; see A. 36-A.39, A. 59-A.60). Thus, the effect of the contractual ban on balance billing is that Blue Shield not only fixes the amount of its insurance liability for each category of medical service but also largely controls the fees that physicians may charge, without regard to individual skill or experience, to the detailed nature of the treatment actually given, or to any other circumstances unique to a particular transaction between physician and patient.[3]

This action was begun in March 1978 to seek an injunction under Section 16 of the Clayton Act, 15 U.S.C. § 26, on the ground that this contractual regulation of fees by insurers violates the Sherman Act.[4] In earlier decisions not material

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trust attack. See *Kartell v. Blue Shield of Massachusetts, Inc.*, 542 F. Supp. 782, 788-791 (D. Mass. 1982). This determination is not challenged here by these petitioners.

[3] In 1982, Blue Shield's "fee schedule system" capped physician compensation for about 46 percent of all covered services (A. 59).

[4] There are no claims for damages in this action. The intervenor-plaintiffs subsequently filed an action seeking treble damages. *Rodkey, et al. v. Blue Shield of Massachusetts, et al.*, D. Mass. No. 82-317-C. That action remains pending in its incipiency.

to the present petition, it was determined that the ban on balance billing is not immune from antitrust scrutiny by reason of the state action doctrine or the McCarran-Ferguson Act's exemption of the "business of insurance," and that it does not violate Section 1 *per se*.[5] These decisions are not material here because petitioners do not pursue any *per se* claim in this Court and because the Court of Appeals did not consider any immunity issues, but decided instead to "proceed directly to the antitrust merits, which, on our view of the case, are dispositive" (A. 5).

These "antitrust merits" were the subject of full discovery and a lengthy non-jury trial on the "one central issue ***: whether, as judged under the rule of reason, Blue Shield's ban on balance billing by participating physicians imposes an unreasonable restraint on competition" (A. 31). Following the trial, the District Court made detailed findings leading to the conclusion that the provision of the Participating Physician's Agreement banning balance billing does in fact unreasonably restrain competition in the market for physicians' services in Massachusetts (A. 67). It therefore entered an injunction against enforcement of that ban (A. 72-A. 73). The Court of Appeals did not set aside any of these findings as clearly erroneous under Fed. R. Civ. P. 52(a), but held that this contractual restraint is permissible as a matter of law notwithstanding its anticompetitive effects; it therefore ordered judgment for Blue Shield.

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[5] *Kartell v. Blue Shield of Massachusetts, Inc.*, 592 F. 2d 1191 (1st Cir. 1979) (reversing dismissal on state action grounds); 384 Mass. 409, 425 N.E.2d 313 (1981) (answering state-law questions concerning state action certified by the District Court), 542 F. Supp. 782 (D. Mass. 1982) (deciding immunity questions and denying plaintiffs' motion for summary judgment on a *per se* price fixing theory). In addition, the Court of Appeals dismissed an appeal by the intervenor-plaintiffs from an order declining to expand the scope of the issues and the relief sought. *Kartell v. Blue Shield of Massachusetts, Inc.*, 687 F.2d 543 (1st Cir. 1982). The prior history of the case is summarized at A. 28-A. 32.

The District Court's Findings.

As previously noted, the District Court found that Massachusetts physicians are economically coerced to agree to Blue Shield's regulation of their fees under the Participating Physician's Agreement. It then went on to examine this contractual restraint under the classic criterion of the rule of reason — *i.e.*, "whether the ban on balance billing has the net effect of *promoting* or *suppressing competition* in the market for physicians' services in Massachusetts" (A. 50).[6] The Court found an absence of procompetitive effects because a mere reduction of prices to a more "reasonable" level than would otherwise prevail is not procompetitive (A. 50-A. 52). By the same token, the Court held that the ban would not violate the rule of reason unless it results in some "'effect on price formation, or other restraint of trade, independent of what the contract terms • • • require'" (A. 56), *i.e.*, "anticompetitive effects that reach beyond the price terms of the provider agreements" (A. 53).

While recognizing the differences between the rule of reason issue before it and the horizontal price fixing issue before this Court in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the District Court looked to *Maricopa's* statement of the competitive dangers of maximum price restraints upon physicians as the touchstone for its rule of reason inquiry:

> "In this case the rule is violated by a price restraint that tends to provide the same economic rewards to all practi-

[6] The Court had previously found that this is the market in terms of which the ban on balance billing should be evaluated, rejecting plaintiffs' further contention that they had standing to complain of adverse effects on competition in the Massachusetts health insurance market (A. 41-A. 46). The Court also rejected Blue Shield's argument that the physicians' services market has special characteristics making application of normal antitrust rules inappropriate (A. 48-A. 50).

> tioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs.* * * "

(A. 59, quoting from 457 U.S. at 348). The District Court went on to find that "many of these anticompetitive effects have materialized in the present case" (*id.*).

The District Court's analysis of the evidence, including both expert testimony and testimony by several physicians as to specific effects of Blue Shield's fee regulation, led it to find that

> "As the Supreme Court predicted in *Maricopa*, those doctors in Massachusetts wanting to compete by offering innovative or 'premium' services — services requiring more of the doctors' time and expenses — are discouraged from doing so because defendants' pricing structure presumes that doctors' services are fungible. Defendant Blue Shield pays all doctors at the same 'customary' maximum price level regardless of their levels of skill, their experience, their willingness to employ new procedures, or the levels of care they provide. Thus, the Blue Shield maximum fee system permits no financial reward for excellence, nor does it provide an incentive for individual qualitative improvement or innovation."

(A. 60). Instead, its effect is to place a premium on "volume — the number of procedures performed" (*id.*). And "Blue Shield's reluctance to provide full remuneration for innovative procedures, coupled with its ban on balance billing, discourages physicians from undertaking the training and purchasing the equipment necessary to learn and offer [an] * * * innovative * * * procedure" (A. 62). The District Court's focus was not on the reasonableness of the amounts that Blue Shield pays, but rather on the fact that the ban on

balance billing precludes differentiation among physicians and thereby eliminates incentives for innovation that would otherwise exist; the Court observed that "it is especially important that during the early, formative development of a medical technique, the market, not Blue Shield, should determine the relative value of the procedure" (A. 62 n. 25).

Accordingly, the District Court concluded that "the restraint has a deleterious effect on competition in [the market for physicians' services in Massachusetts] far exceeding the mere diminution in doctors' earnings that results directly from the terms of the Participating Physician's Agreement" and that "this effect is not offset by any demonstrable procompetitive effect" (A. 67). It found that this impairment of competition "reduces the quality of medical care in Massachusetts because it suppresses the normal market-generated incentives for physicians to improve and refine their services" (*id.*).

The District Court further found that in fact "the ban on balance billing has had no impact on *average* physician practice income." Instead, its effect is that "in Massachusetts, superior physicians are undercompensated and below-average physicians are overcompensated" (A. 63). In other words, the reduction in some fees accomplished by the ban does not contain medical costs in the aggregate, but merely allocates them among individual physicians in a discriminatory manner that eliminates many of the qualitative benefits of an unrestrained market.

The Reasoning Of the Court of Appeals.

In reversing, the Court of Appeals did not purport to set aside a single one of these findings of fact. Instead, it held that "[w]e disagree with the district court because we do not believe that the facts that it found show an unreasonable restraint of trade" (A. 5). It went on to hold categorically that

the contractual restraints by which Blue Shield substantially regulates the economics of medical practice in Massachusetts are permissible as a matter of law — lawful *per se* — regardless of their coercive nature, regardless of Blue Shield's dominant power in the relevant market, and regardless of the extracontractual anticompetitive effects found by the District Court. In other words, the Court of Appeals has decided that conventional rule of reason analysis is irrelevant to the antitrust legality of a health insurer's contractual regulation of provider fees.

The premise of the Court of Appeals' theory of *per se* lawfulness is strikingly simple:

> "The persuasive power of the district court's analysis disappears * * * once one looks at Blue Shield * * * as itself the purchaser of the doctors' services." (A. 6).
> "The [only] relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge. Those facts * * * convince us that Blue Shield's activities here are *like* those of a buyer." (A. 10).

The theory is then developed by abstract deduction. The syllogism proceeds as follows:

> (1) Blue Shield is the purchaser of medical services provided to subscriber patients.
> (2) A purchaser, regardless of its market power, has an unqualified right to set the price at which it will purchase (at least in the absence of below cost pricing by a monopsonist).
> (3) Therefore, Blue Shield has an unqualified right to use its dominant market power to impose contractual fee restraints upon medical services provided to subscriber patients, regardless of the effects on competition in the market for physicians' services.

See A. 7- A. 8; A. 10-A. 14; A. 16. The Court of Appeals found that "*Maricopa* is simply not on point" because it involved a horizontal agreement among physicians and such "agree-

ments by competitors to limit independent decision-making" are categorically different from vertical agreements depriving the same competitors of the power of independent decision-making (A. 18).

The Court of Appeals went on to explain that "three additional circumstances militate strongly" in favor of its approach; although they "do not dictate our result in this case," they "counsel us against" finding antitrust illegality (A. 18-19). These considerations are (1) that "the relevant economic considerations may be very different when low prices, rather than high prices, are at issue" (A. 18); (2) that the subject of medical costs is one "of great complexity where more than solely economic values are at stake" (A. 19); and (3) that "the price system here at issue is one supervised by state regulators," making "strict antitrust scrutiny * * * less likely to be necessary" (*id.*).

Reasons for Granting the Writ

In holding that it is *per se* lawful for health insurers to regulate physicians' fees, the Court of Appeals has decided an important question of antitrust law with great potential impact upon a major segment of the economy. This case presents in its starkest form the question noted but not decided in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 353, n.26 (1982) — "whether an insurer may, consistent with the Sherman Act, fix [a maximum fee] schedule and enter into bilateral contracts with individual doctors" imposing the maximum fee schedule upon them.[7]

As we show in the pages that follow, the Court of Appeals' decision does violence to fundamental Sherman Act principles by categorically endorsing this restraint upon the relationship between physicians and their patients without allow-

[7] The importance of this case is reflected by the fact that both the National Blue Cross and Blue Shield Association and the American Medical Association, among others, filed briefs as *amici curiae* in the Court of Appeals.

ing consideration of the effects upon competition and the quality of medical services found in the District Court's rule of reason analysis. Contrary to the Court of Appeals' claim of consistency with cases in other Circuits on similar subjects, the decision below actually conflicts with the reasoning of those cases, which endorse precisely the kind of rule of reason analysis swept aside in this case. By the same token, the issue now presented has not been presented in the health insurance cases recently brought to this Court,[8] much less on a fully developed trial record followed by an extensively (if erroneously) reasoned appellate decision.

Accordingly, certiorari should be granted both to answer the important question left open in *Maricopa* and to correct the Court of Appeals' serious distortion of antitrust principles.

I. The Court of Appeals Has Departed from Fundamental Sherman Act Principles in Holding a Contract Lawful Even Though Conventional Rule of Reason Analysis Discloses That it has Substantial Net Anticompetitive Effects.

Even if the Participating Physician's Agreement were a simple contract of purchase and sale, such a contract is as much subject to rule of reason analysis as any other. Section 1 of the Sherman Act addresses "*[e]very* contract * * * in restraint of trade." The Court of Appeals has not attempted to explain why this language does not include a contract imposed by a "purchaser," particularly where the contract affects the relationship between the "seller" and the actual consumers of the services "purchased" for them.

[8] *Royal Drug Co. v. Group Life & Health Ins. Co.*, 737 F.2d 1433 (5th Cir. 1984), *cert. denied*, 53 U.S.L.W. 3507 (Jan. 15, 1985); *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 677 F.2d 47 (9th Cir.), *cert. denied*, 459 U.S. 1016 (1982).

While this Court has not specifically applied the rule of reason to the price terms of a purchase contract, it has applied it to other terms of such a contract. *Jefferson Parish Hospital District No. 2 v. Hyde,* 104 S. Ct. 1551, 1561 (1984) (when a tying agreement does not rise to the level of a *per se* violation, nonetheless "an antitrust violation can be established * * * by evidence of unreasonable restraint on competition in the relevant market"); see *Fortner Enterprises Inc. v. United States Steel Corp.,* 394 U.S. 495, 500 (1969) (same); *Tampa Electric Co. v. Nashville Coal Co.,* 365 U.S. 320, 335 (1961) (requirements contract). Assuming — as we do here — that Blue Shield's vertical price restraint is not *per se* illegal, there is no apparent reason why it should not remain subject to similar rule of reason analysis. This Court's recent decision in *National Collegiate Athletic Ass'n v. Board of Regents of the University of Oklahoma,* 104 S. Ct. 2948 (1984) (hereafter *"NCAA"*), has made just such an analysis in the case of horizontal price restraints not illegal *per se.*[9]

The Court of Appeals incorrectly relied on several decisions in other Circuits as "upholding" contractual price restraints by health insurers (A. 8-A. 9). In fact, those decisions merely rejected challenges based entirely or largely upon *per se* theories without any significant evidence of effects on competition, and expressly recognized that such contractual schemes would violate the rule of reason if it were "establish[ed] that [they] imposed an unreasonable restraint on competition among [providers]." *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.,* 675 F.2d 502, 505, 507 (2d Cir. 1982); see *Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pennsylvania,* 1984-2 Trade Cas. (CCH) ¶ 66,214 at p. 66,876 & n.4 (3d Cir. 1984); *Royal Drug Co. v. Group Life & Health Ins. Co.,* 737

[9] This Court noted in *NCAA* that "[t]he fact that a practice is not categorically unlawful in all or most of its manifestations certainly does not mean that it is universally lawful." 104 S. Ct. at 2965 n.39.

F.2d 1433, 1438-1439 (5th Cir. 1984), *cert. denied*, 53 U.S.L.W. 3507 (Jan. 15, 1985); *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F. Supp. 230, 235, 237 (N.D. Cal. 1981), *aff'd per curiam on district court opinion*, 677 F.2d 47 (9th Cir.), *cert. denied*, 459 U.S. 1016 (1982).[10]

Here, in contrast, the District Court found, on a full trial record, that Blue Shield's contractual fee restrictions unreasonably restrain competition in the market for physicians' services in Massachusetts. Their tendency is not merely to reduce particular physicians' compensation for particular services, but more generally to distort the economics of the physician-patient relationship. Blue Shield restrains not only the "trade" between itself and physicians but also the "trade" between physicians and their patients, with adverse effects upon the normal competitive incentives protected by the Sherman Act and thereby upon the quality of medical care.

Contrary to the Court of Appeals' view (A. 17-A. 18), the District Court properly referred to this Court's restatement of the dangers of maximum price fixing in *Maricopa* as the touchstone for determining that these market effects violate the rule of reason. This Court has recently applied the identical *Maricopa* formulation to rule of reason analysis in *NCAA*, 104

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[10] See also *Travelers Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80, 84 (3rd Cir.), *cert. denied*, 414 U.S. 1093 (1973); *Proctor v. State Farm Mutual Auto Ins. Co.*, 675 F.2d 308, 337-338 (D.C. Cir.), *cert. denied*, 459 U.S. 839 (1982); and *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195, 1203 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982), none of which involved any prohibition against balance billing.

It is obviously more difficult to show anticompetitive restraints resulting from price restraints on drugs than from fee restraints upon physicians, since drugs are fungible products whose quality is not affected by retail pricing. In contrast, medical services are by their nature heterogeneous and "tailor made." The cases referred to by the Court of Appeals also differ from the present one because of the lack of evidence of economic coercion in those cases. See A. 53-A. 54.

S. Ct. at 2964 n.33, noting that "whether the ultimate finding is the product of a *[per se]* presumption or actual market analysis, the essential inquiry remains the same — whether or not the challenged restraint enhances competition," *id.* at 2962. This criterion is no less applicable to vertical restraints, for "vertical control destroys horizontal competition as effectively as if [the persons whose prices are controlled] 'formed a combination and endeavored to establish the same restrictions . . . by agreement with each other.'" *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 103 (1980) (quoting from *Dr. Miles Medical Co. v. John D. Park & Sons Co.*, 220 U.S. 373, 408 (1911)).[11] Indeed, the *Maricopa* formulation was expressly derived from, and largely similar to, that in *Albrecht v. Herald Co.*, 390 U.S. 145, 152-153 (1968), which held vertical maximum price fixing unlawful. See 457 U.S. at 347.

The Court of Appeals has held that competitive harms that would normally condemn a contract under the rule of reason are irrelevant because Blue Shield is a "purchaser," *i.e.*, that there are no conceivable circumstances under which an insurer's contractual regulation of physicians' fees, or the price terms of any purchase contract, could violate the antitrust laws. This stark proposition conflicts with the antitrust principles previously established by this Court and with other courts of appeals' views of the proper mode of analysis of health provider fee restraints, and should therefore be reviewed by this Court.

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[11] The District Court appropriately treated Blue Shield's coercive market power and its non-coverage of services by physicians who have not agreed to Blue Shield's terms *not* as grounds for liability in themselves, but rather as attributes of the market environment in the light of which the competitive effects of the ban on balance billing should be evaluted under the rule of reason.

II. The Court of Appeals' Treatment of Health Insurers as Sole Purchasers of Physicians' Services Distorts the Relevant Economic Relationships and Ignores the Interests of Insurance Beneficiaries in a Competitive Market.

The sterile syllogism that the Court of Appeals substituted for normal rule of reason analysis depends on the premise that the Participating Physician's Agreement is simply a contract by which Blue Shield purchases medical services, as well as the corollary notion that a purchaser's desire to pay as little as possible overrides all other considerations. Even if the latter notion were correct in the case of a conventional purchaser of goods and services, it is a serious question whether an insurance indemnitor such as Blue Shield can be equated with a true purchaser in this respect.

Health insurers do have some of the attributes of a purchaser in their relationship to providers, growing out of the obvious fact that they pay at least a large portion of the bill. That is, in part, the reason why provider contracts are not elements of the "business of insurance" exempted by the McCarran-Ferguson Act. See *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979). It is also the reason why the District Court, following precedents in other Circuits, held that Blue Shield's price restraints are not illegal *per se*, a holding that we do not challenge here. See 542 F. Supp. at 795-796; *e.g.*, *Medical Arts Pharmacy of Stamford, Inc.*, *supra*, 675 F.2d at 505.

It is equally obvious, contrary to the Court of Appeals' premise, that Blue Shield does not have *all* of the attributes of a conventional purchaser of goods and services because it is not the consumer of what it pays for. In all respects other than price alone, the normal interests of a purchaser reside in the third party to this three-sided transaction, the individual

subscriber-patient for whose medical services Blue Shield pays. It is the patient, not Blue Shield, who is directly concerned with the qualitative aspects of medical care that the District Court found impaired by restraint of competition among physicians. Whatever a true purchaser might be allowed to do, it is an entirely different question whether the financial interest of an insurer such as Blue Shield may override its *subscribers'* interests in the qualitative benefits of competition among physicians. The Court of Appeals' unqualified affirmative answer to this question is a significant new departure in antitrust doctrine.[12]

The Court of Appeals' effort to analogize Blue Shield's pervasive regulation of the price terms of physician-patient relationships to a father's specification of the price for toys selected by his son or a landlord's contract with a painter (A. 8) is fallacious. That such homely situations instinctively seem lawful is no basis for inferring a categorical antitrust principle that "he who pays the piper may call the tune." Rather, it simply reflects the fact that such atomistic transactions in fungible products or services are unlikely to affect competition. Here, in contrast, we are concerned with a coercively imposed restraint on price competition with factually demonstrated substantial effects on competition in the market and on the quality of the services available to the actual con-

[12] No other court of appeals has adopted the stark "purchaser's rights" reasoning on which the decision below is based. For example, *Medical Arts Pharmacy of Stamford, Inc., supra,* expressly noted that health provider agreements "are not precisely between seller and purchaser (but between seller and indemnitor)," and are therefore "*sui generis*" — not *per se* unlawful insofar as they fix prices but remaining subject to rule of reason analysis. 675 F.2d at 506. *Pennsylvania Dental Ass'n, supra,* similarly observed that there is a "two-sided buyer composed of the insurer and the subscriber." 1984-2 Trade Cas. (CCH) at p. 66,877. In contrast, the syllogistic reasoning of the Court of Appeals is an example of the kind of formalism, divorced from any attention to real effects in the marketplace, that this Court condemned in *Simpson v. Union Oil Co.*, 377 U.S. 13 (1964); see also *NCAA*, 104 S. Ct. at 2967.

sumers. The Court of Appeals' holding that such a restraint is lawful *per se* raises an important antitrust question requiring review by this Court.

III. The Unique Characteristics of Health Insurance Do Not "Counsel Against" Rigorous Application of the Antitrust Laws, But Rather Enhance the Importance of the Issue Raised by the Court of Appeals' Decision.

The "additional circumstances" that the Court of Appeals found to "militate strongly" against finding a violation (A. 18-A. 20) reveal a result-orientation inconsistent with antitrust jurisprudence. The Court of Appeals' desire to protect a mechanism believed to lower the price of medical care is understandable, but it flouts this Court's repeated "refus[al] to tolerate manifestly anticompetitive conduct simply because the health care industry is involved,"[13] as well as the more general principles that neither price reductions[14] nor presumed social benefits[15] can justify restraints upon competition.

The Court of Appeals' intuitive notion that the ban on balance billing reduces medical costs is, in fact, negated by the District Court's undisturbed finding that the ban has no effect at all on *aggregate* fees (as distinguished from their allocation among individual physicians). And the assertion that "strict antitrust scrutiny" has diminished importance because "the price system here at issue is one supervised by state regulators" (A. 19) is directly contradicted by the record. In fact, the parties stipulated that there is no

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[13] *Jefferson Parish Hospital District No. 2 v. Hyde*, *supra*, 104 S. Ct. at 1565 n.42 (1984), citing *Maricopa* and other cases.

[14] *Maricopa*, 457 U.S. at 348, 352 n.25; *Albrecht v. Herald Co.*, *supra*, 390 U.S. at 152-153.

[15] *E.g.*, *NCAA*, 104 S. Ct. at 2969; *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978).

regulatory oversight over the maximum fees for particular categories of medical services, which Blue Shield determines in its sole discretion.[16]

The magnitude of the antitrust issue presented here is enhanced, not diminished, by the fact that the subject matter is purported containment of medical costs. This Court's previous decisions in this area (particularly *Royal Drug* and *Maricopa*) have recognized the need for a clear delineation of the extent to which contractual regulation — as distinguished from possible governmental regulation -- is permitted under the Sherman Act. If the Court of Appeals' decision stands, it will categorically authorize such private regulation by powerful health insurers such as Blue Shield. Whether such a blanket authorization is consistent with the antitrust laws is an important question that should be settled by this Court.

Conclusion

For the foregoing reasons, certiorari should be granted.

Respectfully submitted,

JAMES VANR. SPRINGER
(Counsel of Record)
RONALD K. PERKOWSKI
DICKSTEIN, SHAPIRO & MORIN
2101 L Street, N.W.
Washington, D.C. 20037
(202) 785-9700

STANLEY V. RAGALEVSKY
WARNER & STACKPOLE
28 State Street
Boston, Massachusetts 02109
(617) 725-1400
Attorneys for Petitioners

February 1985

[16] See ¶ 42 of the Stipulation of Facts appearing at pp. 102-103 of the joint appendix in the Court of Appeals.

AA

APPENDICES

Appendix A

United States Court of Appeals for the First Circuit

No. 84-1241

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,
Defendant, Appellant.

No. 84-1290

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET AL.,
Defendants, Appellees.

MASSACHUSETTS MEDICAL SOCIETY, ET AL.,
Intervenors/Plaintiffs, Appellants.

No. 84-1303

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET AL.,
Defendants, Appellees.

COMMISSIONER OF INSURANCE,
Intervenor/Defendant, Appellant.

CROSS-APPEALS FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

[Hon. Andrew A. Caffrey, *U.S. District Judge*]

Before
Campbell, *Chief Judge,*
Cowen,* *Senior Circuit Judge,*
and Breyer, *Circuit Judge.*

Daniel O. Mahoney, with whom *Douglas H. Wilkins, Arthur P. Kreiger, Palmer & Dodge,* and *Reginald H. Howe,* were on brief, for Blue Shield of Massachusetts, Inc., et al.

Helen E. Witt, James W. Rankin, Jack A. Rovner, Kirkland & Ellis, Marvin C. Reiter, Mary Ader, on brief, for Blue Cross and Blue Shield Association, amicus curiae.

John R. Phillips, and *Richard B. Rogers,* were on brief, for Ford Motor Company, amicus curiae.

H. Reed Witherby, Assistant Attorney General, Government Bureau, with whom *Francis X. Bellotti,* Attorney General, and *Donna Arzt,* Assistant Attorney General, Public Protection Bureau, were on brief, for Massachusetts Commissioner of Insurance.

Thayer Fremont-Smith, with whom *Kenneth Laurence, Lee T. Gesmer, Michael K. Loucks,* and *Choate, Hall & Stewart,* were on brief, for Massachusetts Medical Society, et al.

Kirk B. Johnson, with whom, *B.J. Anderson, American Medical Association, Newton N. Minow, Jack R. Bierig, Jeffrey R. Tone, James C. Dechene,* and *Sidley & Austin,* were on brief, for American Medical Association, amicus curiae.

Catherine W. Hantzis on brief for Consumer Health Advocates, Inc., amicus curiae.

James van R. Springer, with whom *Dickstein, Shapiro & Morin, Stanley V. Ragalevsky, Christopher E. Nolin,* and *Warner & Stackpole,* were on brief, for James P. Kartell, M.D., et al.

November 28, 1984

BREYER, *Circuit Judge.* Blue Shield pays doctors for treating patients who are Blue Shield health insurance subscribers, but only if each doctor promises not to make any additional charge to the subscriber. The basic issue in this case is whether this Blue Shield practice — called a "ban on balance billing" — violates either Sherman Act § 1 forbidding agreements "in restraint of trade," 15 U.S.C. § 1, or Sherman Act § 2 forbidding "monopolization" and "attempts to monopolize," *id.* § 2. The district court held that the practice constituted an unreasonable restraint of trade in violation of section 1. We conclude that the practice does not violate either section of the Sherman Act; and we reverse the district court.

As the district court noted, the relevant facts are "not . . . generally . . . disputed." Blue Shield provides health insurance for physician services while its sister, Blue Cross, insured against hospital costs. The consumers of Blue Shield insurance, at least those who buy "full service" prepaid medical benefits, can see any "participating doctor," *i.e.*, a doctor who has entered into a standard Participating Physician's Agreement with Blue Shield. (If a doctor has not signed the Agreement, Blue Shield will reimburse him only if he provides emergency or out-of-state services.) Under the standard agreement, a participating doctor promises to accept as payment in full an amount determined by Blue Shield's "usual and customary charge" method of compensation. The district court found that the method has evolved, through the use of various 'capping' devices, towards payment of a 'fixed fee,' determined by Blue Shield, for each particular type of service. Blue Shield pays this amount directly to the doctor; the patient pays nothing out of his own pocket and therefore receives no reimbursement.

The district court also found that Blue Shield provides some form of health insurance to about 56 percent of the Massachusetts population. (About 45 percent has coverage carrying a 'balance billing' ban.) If one subtracts from the total population universe those Massachusetts residents who rely on government sponsored health care (*e.g.*, Medicare or Medicaid), then Blue Shield (and Blue Cross) provide insurance coverage for about 74 percent of the rest, namely those Massachusetts residents who *privately* insure against health costs. (About 23 percent of that group have coverage with commercial insurers; and about 4 percent subscribe to Health Maintenance Organizations.) Virtually all practicing doctors agree to take Blue Shield subscribers as patients and to participate in its fee plan. Blue Shield payments made under that plan account for about 13 to 14 percent of all "physician practice revenue."

The district court found that, because of the large number of subscribers, doctors are under "heavy economic pressure" to take them as patients and to agree to Blue Shield's system for charging the cost of their care. The court believed that the effect of this payment system, when combined with Blue Shield's size and buying power, was to produce an unreasonably rigid and unjustifiably low set of prices. In the court's view, the fact that doctors cannot charge Blue Shield subscribers more than the Blue Shield payment-schedule amounts interferes with the doctors' freedom to set higher prices for more expensive services and discourages them from developing and offering patients more expensive (and perhaps qualitatively better) services. For these and related reasons, the district court held that Blue Shield's ban on 'balance billing' unreasonably restrains trade, and thereby violates Sherman Act § 1. Blue Shield appeals from this holding. The plaintiff doctors cross-appeal from other rulings of the district court in Blue Shield's favor.

On these appeals, the parties raise a host of issues not directly related to the antitrust merits, including the claim that a recently enacted state law, Mass. St. 1984, ch. 192, § 1, renders the case moot by immunizing Blue Shield's "balance billing ban" from the reach of the antitrust laws. The 'mootness' issue, however, is not a simple one. And even if we accept the mootness claim, the new statute may not immunize the defendants from treble-damage liability for past conduct. In view of these legal and practical problems, and the fact that this case has been pending in the federal courts for more than seven years, we believe it simpler and more appropriate to proceed directly to the antitrust merits, which, on our view of the case, are dispositive.

I

We disagree with the district court because we do not believe that the facts that it found show an unreasonable re-

straint of trade. We can best explain our reasons by first discussing the basic antitrust issue in general terms, then turning to the specific, detailed arguments advanced by the parties, and finally noting several special reasons here that militate against a finding of liability.

A

We disagree with the district court's finding of "restraint." To find an unlawful restraint, one would have to look at Blue Shield as if it were a 'third force,' intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains. Antitrust law typically frowns upon behavior that impedes the striking of such independent bargains. The persuasive power of the district court's analysis disappears, however, once one looks at Blue Shield, not as an inhibitory 'third force,' but as itself the purchaser of the doctors' services. *See Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979) (direct reimbursement to participating pharmacies for subscribers' drugs "merely [an] arrangement[ ] for the purchase of goods and services by Blue Shield"). Antitrust law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold. Thus, the more closely Blue Shield's activities resemble, in essence, those of a purchaser, the less likely that they are unlawful.

Several circuits have held in antitrust cases that insurer activity closely analogous to that present here amounts to purchasing, albeit for the account of others. And, they have held that an insurer may lawfully engage in such buying of goods and services needed to make the insured whole. The Second Circuit has held lawful a Blue Shield plan requiring pharmacies to accept Blue Shield reimbursement as full payment for drugs they supply to Blue Shield subscribers. *Medical Arts*

Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc., 675 F.2d 502 (2d Cir. 1982). The Third Circuit has allowed a hospital cost insurer (Blue Cross) to reimburse hospitals directly (and apparently completely) for services to subscribers. *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973). The Seventh Circuit has permitted auto insurance companies to furnish direct reimbursement to repair shops as payment for the repair services provided to policyholders. *Quality Auto Body, Inc. v. Allstate Insurance Co.*, 660 F.2d 1195 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982).

At the same time, the facts before us are unlike those in cases where courts have forbidden an 'organization' to buy a good or service — cases in which the buyer was typically a 'sham' organization seeking only to combine otherwise independent buyers in order to suppress their otherwise competitive instinct to bid up price. *Mandeville Island Farms, Inc. v. American Crystal Sugar Co.*, 334 U.S. 219, 235 (1948) (horizontal price-fixing by purchasers held *per se* illegal); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940) (same); *National Macaroni Manufacturers Association v. Federal Trade Commission*, 345 F.2d 421 (7th Cir. 1965) (competitors in trade association fixing quantity of scarce component to be used in macaroni held *per se* illegal). No one here claims that Blue Shield is such a 'sham' organization or anything other than a legitimate, independent medical cost insurer. *But, cf. Virginia Academy of Clinical Psychologists v. Blue Shield of Virgina*, 624 F.2d 476 (4th Cir. 1980) (Blue Shield found to be a combination, not of policyholders, but of *physicians*), *cert. denied*, 450 U.S. 916 (1981).

Once one accepts the fact that, from a commercial perspective, Blue Shield in essence 'buys' medical services for the account of others, the reasoning underlying the Second, Third,

and Seventh Circuit views indicates that the ban on balance billing is permissible. To understand that reasoning, consider some highly simplified examples. Suppose a father buys toys for his son — toys the son picks out. Or suppose a landlord hires a painter to paint his tenant's apartment, to the tenant's specifications. Is it not obviously lawful for the father (the landlord) to make clear to the seller that the father (the landlord) is in charge and will pay the bill? Why can he not then forbid the seller to charge the child (the tenant) anything over and above what the father (the landlord) pays — at least if the seller wants the buyer's business? To bring the example closer to home, suppose that a large manufacturing company hires doctors to treat its employees. Can it not insist that its doctors not charge those employees an additional sum over and above what the company agrees to pay them to do the job? In each of these instances, to refuse to allow the condition would disable the buyer from holding the seller to the price of the contract. Yet, if it is lawful for the buyer to buy for the third party in the first place, how can it be unlawful to bargain for a price term that will stick?

Given this argument, it is not surprising the courts have unanimously upheld contracts analogous in various degrees to the one at issue here — contracts in which those who directly provide goods or services to insureds have agreed to cap or forego completely additional charges to those insureds in return for direct payment by the insurer. In addition to *Medical Arts* and *Travelers, supra*, see *Royal Drug Co. v. Group Life and Health Ins. Co.*, 737 F.2d 1433 (8th Cir. 1984) ($2 cap on balance billing for drugs); *Webster County Memorial Hospital, Inc. v. United Mine Workers*, 536 F.2d 419 (D.C. Cir. 1976) (hospital agrees to ban on balance billing in exchange for direct payment by union trust fund); *Proctor v. State Farm Mutual Auto Insurance Co.*, 675 F.2d 308, 337 (D.C. Cir. 1982) (auto repair shops agree to provide repairs at rate set by insurance company), *cert. denied*, 459 U.S. 839

(1982); *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F. Supp. 230 (N.D. Cal. 1981), *aff'd per curiam*, 677 F.2d 47 (9th Cir.) (cap on balance billing by participating pharmacies), *cert. denied*, 459 U.S. 1016 (1982); *Feldman v. Health Care Service Corp.*, 562 F. Supp. 941 (N.D. Ill. 1982) (same); *Pennsylvania Dental Association v. Medical Service Association of Pennsylvania*, 574 F. Supp. 457 (M.D. Pa. (1983), *aff'd* No. 84-5004 (3rd Cir. Oct. 1, 1984) (ban on balance billing for dental services); *Michigan State Podiatry Association v. Blue Cross and Blue Shield of Michigan*, 1982-2 Trade Cas. (CCH) ¶ 64,801 (E.D. Mich. 1982); *Blue Cross and Blue Shield of Michigan, Inc. v. Michigan Association of Psychotherapy Clinics, Inc.*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980); *Davidowitz v. San Diego County Dental Society*, 1983-1 Trade Cas. (CCH) ¶ 65,231 (S.D. Cal. 1983). Scholarly commentators believe that these cases were correctly decided. *See, e.g.*, P. Areeda, Antitrust Analysis 530-31 (1981) ("[I]t is difficult to see what could make [such an] arrangement anticompetitive"). *See also* Comment, 75 Nw. U. L. Rev. 506 (1980).

Two arguments might be made in an effort to distinguish these cases. First, the doctors may claim that Blue Shield is not, in essence, a buyer. Traditionally, doctors have opposed financial arrangements that involved the 'selling' of their services to anyone but the patient. *See* Comment, 63 Yale L.J. 938, 978-80 (1954). And medical associations in the past sometimes have argued that selling services to third parties or related 'corporate practice' might interfere with the absolute ethical obligation that a doctor owes to the patient. *Id.*, (citing, *e.g.*, AMA, Principles of Medical Ethics, ch. 3, art. 5, § 4). Medical associations have not, however, opposed reimbursement by third party insurers, such as Blue Shield, a fact that arguably suggests an important distinction between 'insurance reimbursement' and 'purchasing.'

In our view, however, any such distinction is irrelevant for antitrust purposes. The relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge. Those facts led other courts in similar circumstances to treat insurers as if they were 'buyers.' The same facts convince us that Blue Shield's activities here are *like* those of a buyer. Whether for ethical, medical, or related professional purposes Blue Shield is, or is not, considered a buyer is beside the point. We here consider only one specific argued application of the antitrust laws and we do not suggest how Blue Shield ought to be characterized in any other context.

Second, the doctors seek to distinguish these precedents by pointing to an important district court finding either not present or not discussed in depth in these other cases. The district court here found that Blue Shield is a buyer with significant 'market power' — *i.e.*, the power to force prices below the level that a freely competitive market would otherwise set. They argue that Blue Shield's 'market power' makes a significant difference. We do not agree.

At the outset, we note that Blue Shield disputes the existence of significant 'market power.' It points out that the district court relied heavily upon participation by 99 percent of all Massachusetts doctors in Blue Shield's program, as "prov[ing] ... Blue Shield's economic power." But, Blue Shield says, this by itself proves little. Participating in Blue Shield's program does not stop doctors from taking other patients or from charging those other patients what they like. As long as Blue Shield's rates are even marginally remunerative, 99 percent of all doctors might sign up with Blue Shield if it had only ten policyholders or ten thousand instead of several million.

Blue Shield adds that the record does not prove the existence of the single harm most likely to accompany the existence of market power on the buying side of the market, namely lower seller output. *See* P. Areeda, *supra* at 343 n.20;

R. Posner, *Antitrust*, 5-14, 91-3 (1974). Indeed, here the district court found that the supply of doctors in Massachusetts has "increased steadily during the past decade." Blue Shield also claims that whatever power it possesses arises from its ability as an 'expert' to prevent doctors from charging unknowledgeable patients *more* than a free (and informed) market price. *See generally* Comment, 75 Nw. U. L. Rev., *supra*.

On the other hand, several doctors testified that low prices discouraged them from introducing new highly desirable medical techniques. And, they argue that fully informed patients would have wanted to pay more for those techniques had they been allowed to do so.

To resolve this argument about the existence of market power — an issue hotly debated by the expert economists who testified at trial — would force us to evaluate a record that the district court described as "two competing mountains of mostly meaningless papers." Rather than do so, we shall assume that Blue Shield possesses significant market power. We shall also assume, but purely for the sake of argument, that Blue Shield uses that power to obtain 'lower than competitive' prices.

We next ask whether Blue Shield's assumed market power makes a significant legal difference. As a matter of pure logic, to distinguish the examples previously mentioned one must accept at least one of the following three propositions: One must believe either (1) that the law forbids a buyer with market power to bargain for 'uncompetitive' or 'unreasonable' prices, or (2) that such a buyer cannot buy for the account of others, or (3) that there is some relevant difference between obtaining such price for oneself and obtaining that price for others for whom one can lawfully buy. In our view, each of these propositions is false, as a matter either of law or of logic.

First, the antitrust laws interfere with a firm's freedom to set even uncompetitive prices only in special circumstances, where, for example, a price is below incremental cost. Such a "predatory" price harms competitors, cannot be maintained, and is unlikely to provide consumers benefits. *Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d 227 (1st Cir. 1983). *Cf. United States v. Aluminum Co. of America*, 148 F.2d 416, 437-38 (2nd Cir. 1945) (vertically-integrated aluminum monopolist can both charge an unreasonably high price for ingots *and* set a fabricated product price too low for competing fabricators to survive). Ordinarily, however, even a monopolist is free to exploit whatever market power it may possess when that exploitation takes the form of charging uncompetitive prices. As Professor Areeda puts it, "Mere monopoly pricing is not a violation of the Sherman Act." P. Areeda, *Antitrust Law* § 710 (Supp. 1982). The Second Circuit has recently held that "more than monopoly power is necessary to make the charging of a noncompetitive price unlawful." *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 297 (2nd Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980). *Cf. Monsanto Co. v. Spray-Rite Service Corp.*, 104 S. Ct. 1464 (1984).

The reasons underlying this principle include a judicial reluctance to deprive the lawful monopolist (say a patent monopolist) of its lawful rewards, and a judicial recognition of the practical difficulties of determining what is a "reasonable," or "competitive," price. *See* 2 P. Areeda & D. Turner, *Antitrust Law* §§ 512-14 (1978); 3 *id.* ¶ 710; R. Bork, *The Antitrust Paradox*, 125-29 (1978). As the Supreme Court stated in a different context,

> The reasonable price fixed today may through economic and business changes become the unreasonable price of tomorrow. . . . [W]e should hesitate to adopt a construction making the difference between legal and illegal conduct in the field of business relations depend upon so un-

> certain a test as whether prices are reasonable — a determination which can be satisfactorily made only after a complete survey of our economic organizations and a choice between rival philosophies.

United States v. Trenton Potteries Co., 273 U.S. 392, 397-98 (1927). Thus, where a monopoly is unlawful, antitrust courts typically seek to change the market's structure, "to break up or render impotent the monopoly power which violates the Act." *United States v. Aluminum Co. of America*, 91 F. Supp. 333, 334 (S.D.N.Y. 1950) (citing *Schine Chain Theatres, Inc. v. United States*, 334 U.S. 110, 128-29 (1948)). *See also Standard Oil Co. of New Jersey v. United States*, 221 U.S. 1 (1911). Courts only rarely try to supervise the price bargain directly. 3 P. Areeda & D. Turner, *supra*, ¶ 710 n.2. *Cf. United States v. Glaxo Group Ltd.*, 410 U.S. 52 (1973) (ordering compulsory patent licensing "at reasonable charges"). And, where monopoly power is regulated, the regulator, not the court, bears the burden of determining whether prices are reasonable. *See, e.g.*, Mass. Gen. Laws ch. 164, §§ 93-94 (state regulation of gas and electric rates).

The district court did not suggest here that the prices subject to the 'balance billing' ban were 'predatory.' Nor (with one possible exception, see pp. 30-32) do the parties point to evidence of any price below anyone's 'incremental cost.' *Cf. Barry Wright Corp. v. ITT Grinnell Corp.*, *supra*. Rather, the district court suggested that Blue Shield's prices were 'uncompetitively low,' 'unreasonably low,' lower than the doctors might have charged to individual patients lacking market power. That is to say, Blue Shield obtained prices that reflected its market power. For the reasons just mentioned then, if Blue Shield had simply purchased those services for itself, the prices paid, in and of themselves, would not have amounted to a violation of the antitrust laws. *Berkey Photo, Inc. v. Eastman Kodak Co.*, *supra*; 3 P. Areeda & D. Turner, *supra*, ¶ 710.

Second, as we previously mentioned, there is no law forbidding a legitimate insurance company from itself buying the goods or services needed to make its customer whole. The cases that we have cited are unanimous in allowing such arrangements. The rising costs of medical care, the possibility that patients cannot readily evaluate (as competitive buyers) competing offers of medical service, the desirability of lowering insurance costs and premiums, the availability of state regulation to prevent abuse — all convince us that we ought not create new potentially far-reaching law on the subject. And, the parties have not seriously argued to the contrary.

Third, to reject the first two propositions is, as a matter of logic, to reject the third. If it is lawful for a monopoly buyer to buy for the account of another, how can it be unlawful for him to insist that no additional charge be made to that other? To hold to the contrary is, in practice, to deny the buyer the right to buy for others, for the seller would then be free to obtain a different price from those others by threatening to withhold the service. This reasoning seems sound whether or not the buyer has 'market power.'

In essence, then, the lawfulness of the term in question stems from the fact that it is an essential part of the price bargain between buyer and seller. Whether or not that price bargain is, in fact, reasonable is, legally speaking, beside the point, even in the case of a monopolist. As Blue Shield stresses in its brief, health maintenance organizations, independent practice associations, and preferred provider organizations all routinely agree with doctors that the doctors will accept payment from the plan as payment in full for services rendered to subscribers. We can find no relevant analytical distinction between this type of purchasing decision and the practice before us — even on the assumption that Blue Shield possesses market power.

B

We now consider more closely the specific arguments raised by the district court and the parties to show that Blue Shield's 'balance billing ban' is anticompetitive in practice. The Rodkey plaintiffs' brief sets forth in summary form the following allegedly harmful effects of the ban:

(1) Price competition among physicians for services covered by Blue Shield's service benefit policies is "virtually eliminated."

(2) Doctor's prices have tended to cluster around Blue Shield's "maximum price levels."

(3) Doctors wanting to compete by offering innovative or 'premium' services are inhibited from doing so because Blue Shield's pricing structure assumes that physicians' services are fungible and mandates the same price ceilings for virtually all physicians.

(4) Doctors just entering practice are discouraged from doing so by particularly low levels of Blue Shield reimbursement.

(5) Blue Shield's low prices lead doctors to charge higher prices to others.

(6) Blue Shield discourages doctors from charging others low prices by insisting that its subscribers be given the benefit of any such low prices.

(7) Blue Shield's pricing system discourages doctors from trying out more expensive services that could bring about lower total medical costs, *e.g.*, a "colonoscopy with polypectomy," an expensive service that is nonetheless cheaper than the surgery that would otherwise be needed to cure the patient.

(8) Blue Shield, by reason of its pricing practices, has been able to attract more subscribers, extending its "competitive edge" over other health insurers, and increasing its dominance in the health insurance business.

The first seven of these arguments attack the price term in the agreement between Blue Shield and the doctors. To argue that Blue Shield's pricing system is insufficiently sensitive to service differences, or that it encourages high costs, or does not give the patients what they really need, or to claim that the buyer is making a bad decision is like arguing that the buyer of a fleet of taxicabs ought to buy several different models, or allow the seller to vary color or horsepower or gearshift because doing so either will better satisfy those passengers who use the fleet's services, or will in the long run encourage quality and innovation in automobile manufacture. The short — and conclusive — answer to these arguments is that normally the choice of what to seek to buy and what to offer to pay is the buyer's. And, even if the buyer has monopoly power, an antitrust court (which might, in appropriate circumstances, restructure the market) will not interfere with a buyer's (nonpredatory) determination of price.

Thus, the arguments that Blue Shield's payments for doctors' services are "too low" are disposed of by our discussion at pp. 16-18 [A. 12-A. 13] *supra*. A legitimate buyer is entitled to use its market power to keep prices down. The claim that Blue Shield's price scheme is "too rigid" because it ignores qualitative differences among physicians is properly addressed to Blue Shield or to a regulator, not to a court. There is no suggestion that Blue Shield's fee schedule reflects, for example, an effort by, say, one group of doctors to stop other doctors from competing with them. *Cf. Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, supra.* Here Blue Shield and the doctors "sit on opposite sides of the bargaining table," *Royal Drug Co. v. Group Life & Health Insurance Co.*, 737 F.2d at 1438. And Blue Shield seems simply to be acting "as every rational enterprise does, *i.e.*, [to] get the best deal possible," *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d at 84. The first seven adverse consequences to which appellees point are the result of this unilateral behavior.

Plaintiffs' eighth argument focuses on the health insurance business: Blue Shield's 'ban on balance billing,' by attracting more subscribers, augments its share of the health insurance business, thereby enabling it to secure still lower doctor charges. This argument, however, comes down to saying that Blue Shield can attract more subscribers because it can charge them less. If Blue Shield is free to insist upon a lower doctor charge, it should be free to pass those savings along to its subscribers in the form of lower prices. This conclusion does not rest upon a judgment about the reasonableness of the doctor charge. A monopolist who charges his customers a high price is free to pay his suppliers more, thereby attracting higher quality raw materials. Considered in and of itself, higher quality, like lower prices, is good — even if it helps the monopolist maintain his market power through "superior skill, foresight and industry." *See United States v. Aluminum Co. of America,* 148 F.2d at 429.

Finally, the district court rested its decision in large part upon the Supreme Court's recent case, *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982). *Maricopa,* however, involved a *horizontal* agreement among competing doctors about what to charge. A horizontal argeement among competitors is typically unlawful because the competitors prevent themselves from making *independent* decisions about the terms as to which they will bargain. Competitors cannot *agree,* for example, to insist that their contracts with sellers contain arbitration clauses, even though each individual competitor can make up his own mind to insist upon such a term in any, or all, of his contracts. *United States v. First National Pictures, Inc.,* 282 U.S 44 (1930); *Paramount Famous Lasky Corp. v. United States,* 282 U.S. 30 (1930). The unlawfulness of the agreement does not necessarily depend upon the undesirability of the contractual term as to which competitors agree not to compete.

The district court saw a similarity between the horizontal agreement cases and this one in the fact that Blue Shield can extract an "uncompetitive price" from doctors while the *Maricopa* court feared that "price-fixing" by competitors might bring about uncompetitive prices. But, the antitrust problems at issue when a single firm sets a price — whether, when, and how courts can identify and control an individual exercise of alleged market power — are very different from those associated with agreements by competitors to limit independent decision-making. A decision about the latter is not strong precedent for a case involving only the former. *Maricopa* is simply not on point. Nor, for similar reasons, is *National Collegiate Athletic Association v. Board of Regents*, 52 U.S.L.W. 4928 (U.S. June 27, 1984), another "horizontal agreement" case cited by the doctors.

C

Three additional circumstances militate strongly here against any effort by an antitrust court to supervise the Blue Shield/physician price bargain. These three considerations convince us to apply mainstream antitrust doctrine, which allows a buyer or seller freedom to bargain for price, rather than to seek analogies with more unusual cases that do not.

First, the prices at issue here are low prices, not high prices. *See* Comment, 75 Nw. L. Rev. at 522-23. Of course, a buyer, as well as a seller, can possess significant market power; and courts have held that *agreements* to fix prices — whether maximum or minimum — are unlawful. *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951); *Albrecht v. Herald Co.*, 390 U.S. 145 (1968). Nonetheless, the Congress that enacted the Sherman Act saw it as a way of protecting consumers against prices that were too *high*, not too low. *See*, R. Bork, *supra*, at 61-2. And, the relevant economic considerations may be very different when low

prices, rather than high prices, are at issue. These facts suggest that courts at least should be cautious — reluctant to condemn too speedily — an arrangement that, on its face, appears to bring low price benefits to the consumer. *See Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d at 231-34.

Second, the subject matter of the present agreement — medical costs — is an area of great complexity where more than solely economic values are at stake. How to provide affordable, high quality medical care is much debated. And, many different solutions — ranging from stricter regulation to greater reliance on competing service organizations — have been proposed. *See* Clark, "Why Does Health Care Regulation Fail?" 41 Md. L. Rev. 1 (1981); A. Enthovin, *Health Plan* (1980). This fact, too, warrants judicial hesitancy to interfere.

Third, the price system here at issue is one supervised by state regulators. See *Kartell v. Blue Shield of Massachusetts, Inc.*, 384 Mass. 409, 422, 425 N.E.2d 313 (1981). While that fact does not automatically carry with it antitrust immunity, *see Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976), it suggests that strict antitrust scrutiny is less likely to be necessary to prevent the unwarranted exercise of monopoly power. Of course, administrative regulation is a highly imperfect process. But, regulation by judicial decree is not necessarily preferable.

These general considerations do not dictate our result in this case. They do, however, counsel us against departing from present law or extending it to authorize increased judicial supervision of the buyer/seller price bargain. Like the court in *Feldman v. Health Care Corp.*, we see "no need to blaze new trails," 562 F. Supp. at 946. Without such pioneering, we do not believe the antitrust laws forbid Blue Shield's 'balance billing' practice. Contrary to the district court's conclusion, the practice does not constitute an unreasonable restraint of trade. And, the same reasons that lead us to this

conclusion also lead us to agree with the district court that the practice does not constitute monopolization or an attempt to monopolize. *See* 3 P. Areeda & D. Turner, *supra*, ¶ 626 at 83.

III

We turn now to four issues that the plaintiff doctors raise in their cross-appeal from other rulings of the district court — rulings that dismissed various parts of their case against Blue Shield (and against Blue Cross, Blue Shield's sister organization). The fact that we have found Blue Shield's ban on balance billing to be lawful simplifies the issues on the cross-appeal and virtually determines an outcome in defendants' favor.

First, the doctors argue that the district court wrongly dismissed their claim that Blue Shield's refusal to reimburse nonparticipating doctors (except for emergency or out-of-state services) violated the antitrust law. The district court found that Blue Shield's actions were immunized from antitrust attack by a prong of the "state action" doctrine which removes actions required (or forbidden) by state laws from the scope of the federal antitrust laws. *See Hoover v. Ronwin*, 52 U.S.L.W. 4535 (U.S. May 14, 1984). The Massachusetts Supreme Judicial Court has held that state law, namely Mass. Gen. Laws ch. 176B, § 7 prohibits Blue Shield from generally reimbursing nonparticipating doctors, *Kartell v. Blue Shield of Massachusetts, Inc.*, 484 Mass. 409, 423, 425 N.E.2d 321 (1981).

The doctors here argue that Massachusetts state law cannot immunize Blue Shield's conduct because the relevant Massachusetts state law is preempted by federal pension law — the Employment Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1381 — and it is therefore without legal effect. We need not trace the labyrinthine path of this preemp-

tion argument, however, for we uphold the district court's ruling for a simpler reason. Since there is no relevant factual dispute, we have examined the legal merits of the doctors' substantive antitrust claim. We conclude that the facts to which they point do not make out a violation of the antitrust laws. No trier of fact, whether judge or jury, could properly find in their favor.

The doctors charge that Blue Shield simply refuses to deal with doctors who do not agree to participate in its program. The doctors strongly argued that this 'refusal to deal' helped Blue Shield implement its ban on balance billing. Were that ban unlawful, the 'refusal to deal' conceivably could have been found unlawful, too, as an unjustified means towards that unlawful end. If the ban is lawful, however, the 'refusal to deal' charge must rise, or fall, on its own. And, on its own, it runs squarely into basic antitrust law that a firm "generally has a right to deal, or refuse to deal, with whomever it likes, as long as it does so independently." *Monsanto Co. v. Spray-Rite*, 52 U.S.L.W. at 4343; *United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919). There is nothing special here to take this case outside the general rule. There is neither evidence of a horizontal conspiracy nor any charge that Blue Shield agreed with one of its competitors not to deal with nonparticipating doctors. *Cf. Fashion Originators' Guild of America v. Federal Trade Commission*, 312 U.S. 457 (1941) (horizontal agreement to boycott certain customers held illegal). Any participation by Blue Cross in Blue Shield's decision is beside the point, for Blue Cross (a hospital cost insurer) does not compete with Blue Shield, nor does it maintain any relevant balance billing ban of its own. Thus, its (alleged) participation does not compromise in any relevant way the *independence* of Blue Shield's dealing decisions (anymore than, say, a hypothetical Blue Shield meeting with a business consultant). *Cf. Copperweld Corp. v. Independence Tube Corp.*, 52 U.S.L.W. 4821, 4825 (U.S. June 19, 1984). In

a nutshell, Blue Shield's independent determination of the terms on which it will deal, of the customers to whom it will sell, and of the suppliers from whom it will purchase is a manifestation of the competitive process, not an effort to suppress or to destroy that process. *Cf. Chicago Board of Trade v. United States*, 246 U.S. 231, 238 (1918) ("The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.").

Second, the doctors charge that Blue Shield engaged in "predatory" pricing behavior. And, they point to one instance, allegedly supported by the record, when Blue Shield charged a lower price for insurance than a competitor (a firm called GISC), and it later turned out that Blue Shield lost money on the policies. The district court held that the injury suffered as a result of any such predatory conduct, occurred only in the market for insurance; and the doctors did not have a sufficiently direct interest in competitive injuries in that market to give them 'standing' to complain of anticompetitive activity there.

On this appeal, the doctors challenge the court's ruling denying them standing to assert this Sherman Act § 2 claim. Like their first challenge, their argument would be far stronger had they prevailed on the 'balance billing' claim. Then, one might have accepted their claim that this single instance of "predatory pricing" was part and parcel of a bundle of anticompetitive activities designed to give Blue Shield significant market power in the medical insurance business. *See* Plaintiffs' First Amended Complaint, ¶ 18. And, anticompetitive activities that significantly lessen competition in that business can harm not only other insurance firms, 2 P. Areeda & D. Turner, *supra* ¶ 340a, but also customers of insurance firms, *id.* ¶ 337, and suppliers of insurance firms (such as doctors), *id.* ¶¶ 338-39. These harms, plaintiffs

assert, were great enough, and direct enough, to confer on suppliers (such as doctors) standing to complain of the anticompetitive conduct in a lawsuit and to seek equitable relief.

Once the 'balance billing' claim is eliminated, however, the doctors' argument lacks plausibility. They can no longer argue that insurance prices that reflect Blue Shield's 'balance billing' rule are automatically unlawful. The "predatory pricing" charge must stand on its own, and to succeed it requires a showing that the price was below "incremental cost" (or the equivalent). *See Barry Wright Corp. v. ITT Grinnell Corp., supra.* The only evidence to which the doctors can now point is the single, isolated instance in respect to GISC. GISC accounted for less than 1.0 percent of the health insurance market. Thus, even if the "predatory pricing" charge is true in respect to GISC, there is no evidence that the charged conduct could lead to any significant increase in Blue Shield's market power. Under these circumstances the possibility of injury to a supplier is simply too remote and indirect to allow a supplier to bring suit. Were the suit one for treble damages, the supplier's injury would be far too indirect to confer standing, *see Associated General Contractors of California v. California State Council of Carpenters,* 459 U.S. 519 (1983) (standing to assert treble-damages claim under § 4 of Clayton Act denied where plaintiff's injury was "indirect" and chain of causation tenuous). Although standing rules for an injunctive action under § 16 of the Clayton Act are more liberal, plaintiffs still must show that the charged conduct threatens them with harm. *Hawaii v. Standard Oil co.,* 405 U.S. 251, 260-62 (1972); 2 P. Areeda & D. Turner, *supra,* ¶¶ 328a, 335e. Plaintiffs cannot show this in respect to the GISC type of conduct. Thus, without the support of a 'balance billing' claim, the doctors cannot obtain a reversal of the district court's ruling that they lacked standing to complain of "predatory pricing."

Third, the doctors attack the district court's dismissal of their claims against Blue Cross. Massachusetts state law ex-

pressly authorizes Blue Cross and Blue Shield to contract with each other "for the joint administration of their business and for joint and co-operative writing and issuing of certificates." Mass. Gen. Laws ch. 176A, § 5; *see also id.*, ch. 176B, § 3. The district court therefore found that the "state action" doctrine and the McCarran-Ferguson antitrust exemption for the "business of insurance," 15 U.S.C. §§ 1011 *et seq.*, immunized Blue Cross's challenged conduct from antitrust scrutiny. Again, we need not accept the doctors' invitation to enter the legal thickets that surround these doctrines, for, with the demise of their 'balance billing' claim, the doctors are no longer able to make any plausible charge of a substantive antitrust violation. Once the ban on 'balance billing' is seen as permissible, the doctors' allegation against Blue Cross amounts to a claim that it conspired or agreed with Blue Shield to achieve a *lawful* objective, not an unlawful one. Blue Cross, concededly, is not a competitor of Blue Shield. There is no claim that the fact of agreement, in and of itself, inhibits any otherwise independently competitive action. *Cf. Fashion Originators' Guild of America v. Federal Trade Commission, supra.* Under these circumstances, the agreements violate no principle of antitrust law of which we are aware. Even were the agreements subject to substantive antitrust scrutiny, the doctors have failed to show us anything about them that would allow a finding of unlawfulness.

Fourth, and finally, the doctors assert the Blue Shield "has engaged in coercive attacks designed to intimidate and retaliate against physicians" — evidently those who oppose the ban on balance billing. As far as we can tell from the briefs, however, the activities that the doctors allege do not make out independent violations of the antitrust laws, once one accepts the fact that Blue Shield's balance billing rule is lawful. Even viewed in a light most generous to plaintiffs, the conduct they complain of at most might amount to minor

business torts, which lie beyond the purview of the antitrust laws, *see* 3 P. Areeda & D. Turner, *supra* ¶ 626d.

For these reasons, the district court's finding that the ban on balance billing is unlawful is reversed, and the district court's injunction is vacated. In all other respects the order of the district court is affirmed.

United States Court of Appeals
For the First Circuit

No. 84-1241

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,
Defendant, Appellant.

No. 84-1290

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET AL.,
Defendants, Appellees.

MASSACHUSETTS MEDICAL SOCIETY, ET AL.,
Intervenors/Plaintiffs, Appellants.

No. 84-1303

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET AL.,
Defendants, Appellees.

COMMISSIONER OF INSURANCE,
Intervenor/Defendant, Appellant.

ERRATA SHEET

Please make the following correction in the opinion in the above case released on November 28, 1984:

At the bottom of the second page of the cover sheet insert the following footnote:

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* Of the U.S. Court of Appeals for the Federal Circuit, sitting by designation."

Appendix B

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

JAMES P. KARTELL, M.D., et al,
Plaintiffs

v. CIVIL ACTION
NO. 78-594-C

BLUE SHIELD OF MASSACHUSETTS, INC., et al,
Defendants.

OPINION

March 19, 1984

CAFFREY, Ch. J.

This is a private civil antitrust action which was originally filed against Blue Shield of Massachusetts, Inc. (Blue Shield) and Blue Cross of Massachusetts, Inc. (Blue Cross) in March of 1978 by four Massachusetts physicians. They request injunctive relief under § 16 of the Clayton Act, 15 U.S.C. § 26, for alleged violations of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. The Massachusetts Commissioner of Insurance (the Commissioner) intervened as a party defendant in August 1979, and, in January 1982, by order of another judge of this Court, the Massachusetts Medical Society (the Society), Grant V. Rodkey, M.D. and Henry Brown, M.D. (collectively, "intervenor-plaintiffs") were permitted to intervene "as parties in the existing complaint."

The route from initial filing of the complaint six years ago to the 37-day non-jury trial of the case before this Court has been circuitous and tortuously slow, replete with procedural skirmishes and internecine disputes among plaintiffs who are represented by three different law firms. The case has been

assigned to five different judges of this Court, the first four of whom recused themselves. In one form or another, the matter has already been before the Supreme Judicial Court of Massachusetts on certified questions of Massachusetts law, and it has been before the Court of Appeals for the First Circuit on two occasions on appeals from rulings made by other members of this Court.

The original complaint was filed on March 10, 1978, and amended shortly thereafter. In the amended complaint, plaintiffs, now joined by intervenor-plaintiffs, allege that Blue Shield, in concert with Blue Cross, has restrained trade illegally in Massachusetts in both the market for physicians' services and the market for health insurance, in violation of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. Specifically, plaintiffs allege[1] that Blue Shield engaged in unlawful price setting and restraint of trade in two ways: first, by requiring in most cases that physicians who have signed Participating Physicians' Agreements accept Blue Shield's reimbursement as payment in full; second, by refusing to reimburse doctors who have not signed Participating Physicians' Agreements with Blue Shield for services rendered by them to Blue Shield subscribers, except for services rendered in emergencies or rendered outside of Massachusetts.[2]

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[1] As is explained more fully below, the only remaining claim is that challenging the ban on balance billing.

[2] The plaintiffs also complain (1) that Blue Cross helps perpetuate Blue Shield's control over the compensation that can be earned by physicians by refusing generally to compensate physicians other than salaried health care providers on the staffs of institutions, primarily hospitals, that enter into agreements with Blue Cross; (2) that Blue Shield directs its subscribers not to use non-participating physicians, and its participating physicians not to refer patients to non-participating physicians; and (3) that Blue Cross directs its participating hospitals not to employ non-participating physicians.

On August 3, 1978, the Honorable Walter J. Skinner dismissed the amended complaint on the grounds that the challenged practices are compelled by state law, and are thus immune from antitrust attack under the "state action" doctrine enunciated by the Supreme Court in *Parker v. Brown*, 317 U.S. 341 (1943). The Court of Appeals for the First Circuit vacated that judgment in *Kartell v. Blue Shield of Massachusetts, Inc.*, 592 F.2d 1191 (1st Cir. 1979), ruling that the district court should have abstained from deciding the state law question — whether defendants' allegedly illegal practices were required by state statute. The Court of Appeals directed Judge Skinner to await the outcome of a case then pending before the Supreme Judicial Court of Massachusetts, *Nelson v. Blue Shield of Massachusetts, Inc.*, 577 Mass. 746 (1979), in which that issue was likely to be decided. The Court of Appeals added that, if the decision in the *Nelson* case did not provide sufficient guidance, Judge Skinner should consider certifying the relevant questions of state law to the Supreme Judicial Court for its consideration. *Id.* at 1195.

After determining that the Supreme Judicial Court's decision in *Nelson* did not speak to the statutory issues central to this case,[3] Judge Skinner certified two questions to the Supreme Judicial Court in January 1981. The questions were:

> 1. Is Blue Shield of Massachusetts, Inc. compelled by M.G.L. c. 176B, § 7 or any other Massachusetts statute or required by any clearly articulated and affirmatively expressed State policy (a) to limit fees of participating physicians as described in the annexed Stipulation and (b) to refuse to make payments for non-emergency services provided in Massachusetts by physicians who decline to accept the terms imposed by Blue Shield in their participation agreement, including such limitation of fees?

[3] In *Nelson*, the Supreme Judicial Court ultimately dismissed the complaint on the grounds that plaintiffs had failed to exhaust their administrative remedies.

> 2. Is Blue Cross of Massachusetts, Inc. permitted generally under the Massachusetts statutes to make payments to subscribers or physicians for medical services provided by physicians to Blue Cross-Blue Shield subscribers, as it does under its contract insuring employees of the Commonwealth?

The Supreme Judicial Court answered the certified questions on August 20, 1981, in *Kartell v. Blue Shield of Massachusetts, Inc.*, 1981 Mass. Adv. Sh. 1980 (1981). The Supreme Judicial Court's ruling enabled this Court to entertain cross-motions for summary judgment in April 1982.[4] In its memorandum and order of June 30, 1982, this Court held that the state action doctrine of *Parker v. Brown, supra*, immunizes most of the challenged conduct from antitrust attack. *Kartell v. Blue Shield of Massachusetts, Inc.*, 542 F. Supp. 782 (D. Mass. 1982). This Court ruled, however, that, to the extent that plaintiffs' complaint challenged Blue Shield's ban on balance billing, described *infra*, it is not barred by either the state action doctrine or the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, which exempts from the federal antitrust laws "the business of insurance . . . regulated by State law." *Id.* § 1012(b). This Court ruled, moreover, that it should not apply a "per se" price-fixing analysis to the ban on balance billing, but rather that it should apply a "rule of reason" analysis. Thus four years of legal sifting have yielded one central issue for this Court to resolve at trial: whether, as judged under the rule of reason, Blue Shield's ban on balance billing by participating physicians imposes an unreasonable restraint on competition.

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[4] The case was transferred to the undersigned on March 8, 1982, after Judge Skinner recused himself.

When I first met with counsel in this case on April 1, 1982, I informed them that I had subscribed to Blue Cross/Blue Shield for many years, and continue to subscribe to the program. I then asked counsel to make any objections to my hearing the case a matter of record at that time. None of the parties objected.

The case was tried non-jury to this Court for 37 trial days, beginning on April 19 and continuing until June 23, 1983. Plaintiffs and intervenor-plaintiffs called 24 witnesses for their case in chief and four rebuttal witnesses, resting their case on June 2, 1983. Defendants Blue Cross and Blue Shield called 12 witnesses between June 6 and June 22, and two witnesses in surrebuttal. Plaintiffs offered 176 exhibits which were accepted into evidence by the Court; defendants offered, and the Court accepted, 105 exhibits. These exhibits run to hundreds of pages containing thousands of numbers. This over-production has given the court the near-impossible task of deciding the credibility of two competing, undigestible piles of paper.[5] The Commissioner of Insurance called no witnesses and offered no exhibits.

This opinion will constitute the Court's findings of fact and conclusions of law pursuant to Fed.R.Civ.P. 52(a).

I. Parties

A. Plaintiffs

1. Plaintiffs James P. Kartell, M.D. and Herbert W. Horne, M.D. and the intervenor-plaintiff Henry Brown, M.D. are physicians who reside in and are licensed to practice medicine in Massachusetts. They do not participate in Blue Shield's medical service plan and are not parties to any written agreement with Blue Shield with respect to the performance of medical or surgical services.

2. Plaintiff Harry D. Wilson, M.D. and intervenor-plaintiff Grant V. Rodkey, M.D. are physicians who reside in and are licensed to practice medicine in Massachusetts. They participate in the medical service plan administered by Blue Shield and each has executed a Participating Physicians' Agreement.

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[5] Counsel for all parties in the case were unresponsive and unhelpful when the Court asked them for their suggestions as to how they expected the Court to resolve the credibility of these two competing mountains of mostly meaningless papers.

3. The intervenor-plaintiff Massachusetts Medical Society is a non-profit, special act corporation organized and existing under the laws of the Commonwealth of Massachusetts. Its 11,000-12,000 members include both participating and non-participating physicians.

B. Defendants

1. The defendant Blue Shield of Massachusetts, Inc., is a private, non-profit medical service corporation organized and existing under the laws of Massachusetts, with a principal place of business at 100 Summer Street, Boston, Massachusetts. Blue Shield is the only medical service corporation organized under Chapter 176B of the Massachusetts General Laws.

2. The defendant Blue Cross of Massachusetts, Inc., is a private, non-profit hospital service corporation organized and existing under the laws of Massachusetts, with a principal place of business also at 100 Summer Street, Boston, Massachusetts. Blue Cross is the only hospital service corporation organized under Chapter 176A of the Massachusetts General Laws.

3. The intervenor-defendant Commissioner of Insurance for the Commonwealth of Massachusetts is responsible under Chapter 176B of the Massachusetts General Laws to oversee and approve the structure and practices of Blue Shield.[6]

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[6] As this Court noted in its memorandum and order of June 30, 1982, 542 F. Supp. at 788, the Supreme Judicial Court of Massachusetts rejected defendants' claim that M.G.L. c. 176B invests in the Commissioner such absolute control over Blue Shield's operations that *any* existing Blue Shield scheme must necessarily be viewed as state policy and thus beyond the purview of federal antitrust law. *See Kartell v. Blue Shield of Mass., Inc.*, 1981 Mass. Adv. Sh. at 1992-94.

II. The Facts

Although this case has been pending for six years, the material facts have not changed since the original filing, nor, generally, are they disputed.[7]

Blue Shield is a medical service corporation, and Blue Cross is a hospital service corporation. They are organized under state law to provide "for the preservation of the public health by furnishing medical services at low cost to members of the public who become subscribers." 1941 Mass. Acts c. 306, preamble; Mass. G.L. c. 176B (Blue Shield); c. 176A (Blue Cross). As permitted by Mass. G.L. c. 176B, § 3, and c. 176A, § 5, Blue Shield has joined with Blue Cross for the joint administration of their affairs and for the issuance of joint subscriber contracts for both medical and hospital services.

Blue Shield directly compensates those doctors who participate in its medical services plan for services they render to about 90% of Blue Shield's subscribers. Participating physicians, in turn, agree to accept Blue Shield's payments (Blue Shield's "allowable") as payment in full for their services, even if the amount Blue Shield determines it will pay is less than the doctor's normal charge for his services. Participating doctors may not bill their patients for the balance. This feature is known as Blue Shield's ban on balance billing. Except in a few cases not of concern here, Blue Shield does not directly remunerate subscribers in any manner, and does not remunerate non-participating physicians for services rendered to subscribers, unless such services are rendered in an emergency, or are rendered outside the Commonwealth.[8]

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[7] For a more detailed history of Blue Shield and its reimbursement systems, see the opinion of the Supreme Judicial Court in *Kartell*, 1981 Mass. Adv. Sh. at 1985-89.

[8] As this Court held in its memorandum and order of June 30, 1982, 542 F. Supp. at 790-91, the refusal to remunerate non-participating physicians is, in and of itself, immune from antitrust challenge under the state action doctrine of *Parker v. Brown*, *supra*.

Blue Cross, on the other hand, is authorized by statute to provide coverage to its subscribers for hospital care and related procedures. Blue Cross does not remunerate physicians for services rendered to Blue Cross subscribers except those physicians who are salaried members of the staffs of institutions, primarily hospitals, which have entered into agreements with Blue Cross.[9]

Blue Shield provides some form of health insurance to at least 3.2 million Massachusetts residents, or 56% of the population of the Commonwealth. Approximately 99% of the state's doctors in fee-for-service practice participate in Blue Shield's medical service plan.

Blue Shield was incorporated under Mass. G.L. c. 176B in May 1942. On September 18, 1942, the Commissioner of Insurance, pursuant to his powers under c. 176B, gave his approval to the first subscription contract, and to the first schedules of subscriber rates and physician fees. He also approved the initial Participating Physicians' Agreement, which remains unchanged to this day. The agreement provides in relevant part that:

> [t]he Participating Physician agrees to accept as full compensation for all . . . services such payments as are received from the Corporation . . . except in the case of those persons who are entitled only to Limited Indemnification, in which case the physician may make his customary charge to the patient for his services, crediting against such charge the amount set forth for such services in the fee schedule in effect at the time the services are rendered.

The original subscription certificate created two classes of subscribers. "Unlimited" subscribers, whose personal or family income was below a certain figure, received unlimited

[9] Blue Cross also reimburses those physicians who treat Massachusetts state employees who are subscribers under a Blue Cross plan available only to employees of the Commonwealth.

coverage from doctors in return for their premium payments. "Limited" subscribers, whose income was above a certain figure, could be balance billed by participating physicians for charges in excess of Blue Shield's allowable. This method of classification was known as "Plan A."

In 1951, Blue Shield implemented a second plan, known as "Plan B," to supplement Plan A. The new plan divided the class of "unlimited" subscribers into two subclasses based on their income levels. Blue Shield charged the higher income subscribers higher premiums and Blue Shield paid participating physicians a higher allowable for services rendered to those subscribers. Blue Shield continued to allow participating physicians to balance bill limited subscribers.

In 1956, Blue Cross and Blue Shield initiated the Master Medical Certificate, which provided comprehensive coverage of hospital and medical costs under a single plan. They continued to determine the extent of an individual subscriber's coverage according to his or her income.

In Blue Shield's first years of operation, nearly 90% of its subscribers were "unlimited" subscribers, and thus were not subject to balance billing by participating physicians. However, this percentage gradually declined during the late 1950's and 1960's, in part due to the effect of inflation on the real value of Blue Shield's fixed income limits. By 1967, fewer than 50% of Blue Shield's subscribers were still below the prescribed income levels, leaving more than half the subscribers subject to balance billing. I find that Blue Shield came under increased pressure from its subscribers to devise a new coverage that would provide full service benefits to subscribers regardless of their income levels.

At the same time, a growing number of doctors were becoming dissatisfied with the reimbursement system. I find that a 1966 survey showed that "90% of the doctors in the state of Massachusetts accept the Blue Shield fee whether or not their patient is over income." However, Blue Shield pay-

ments for most services on the fee schedules had not been raised since 1952 even though doctors' charges had increased significantly in the intervening 15 years. By 1967-68, Blue Shield payments were on the average 30% below the fees usually charged by doctors.

In late 1967 or early 1968, in an attempt to respond to the rising tide of criticism from both subscribers and doctors, Blue Shield submitted to the Commissioner of Insurance a proposed "Amended Schedule of Benefits — Blue Shield Portion of the Blue Cross — Blue Shield Master Medical Certificate," which introduced the "usual and customary charge" method of compensation. The 1968 Amended Schedule of Benefits was approved by the Commissioner of Insurance effective February 1, 1968.

Under the usual and customary charge method of compensation adopted in 1968, the basic mechanics of which are still in use today, Blue Shield did not pay a predetermined, fixed amount for a service as it had under the earlier, fixed-fee system. Rather, the participating physician received from Blue Shield a payment of 95% of the lowest of (a) the doctor's submitted charge, (b) the doctor's "usual charge" (Level I), or (c) the "customary charge" for the service (Level II). Blue Shield deducts five percent to cover administrative costs. A doctor's "usual charge" for a given service is the median of the individual doctor's charges reported to Blue Shield during the applicable charge reporting period. The "customary charge" for a given service is the 90th percentile of the usual charges reported by doctors within the same specialty and geographic area during the applicable charge reporting period. Under the usual and customary charge method, participating physicians were not permitted to balance bill their patients.

As originally implemented, the new system contained no limitation on year-to-year increases in the usual and customary charge levels. While participating physicians were re-

quired under this method of compensation to accept Blue Shield's fees as payment in full for covered services regardless of a subscriber's income,[10] the advantage of this system to participating physicians was the "promise of higher fees immediately for many services and relatively automatic future adjustments for inflation." *Kartell*, 1981 Mass. Adv. Sh. at 1988.

From 1968 until 1975, Blue Shield updated usual and customary charges as it deemed appropriate, without objection from the Commissioner. However, in the eighteen months preceding April 30, 1976, Blue Shield's reserves plunged nearly $25 million. In an effort to contain costs and restore fiscal health to the corporation by rebuilding its reserves, Blue Shield indefinitely deferred the 1976 profile update. By March 1, 1977, the financial condition of the corporation had improved. Blue Shield then filed an amended schedule of benefits designed, according to the testimony of its President, John Larkin Thompson, to reinsure fiscal stability and to provide cost containment. The 1977 Amended Schedule of Benefits was approved by the Commissioner of Insurance and incorporated by reference in the Participating Physicians' Agreement. It provided that the percentage increase in usual and customary payments may be "limited to such amount as Blue Shield may determine" without regard to any specific formula, and that the percentage increase in "customary charges" for the applicable period may not exceed the percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers, Boston, All Items, less the medical care component of the Index.

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[10] When this method was first proposed in 1968, it was to be implemented only for group accounts under the Master Medical Certificate and for Blue Shield's coverage of the Federal Employee Program. At present, however, it applies to all accounts except the few remaining Plan B subscribers. Approximately 90% of Blue Shield members now have coverage which includes the ban on balance billing.

Prior to July 1, 1977, the date on which the 1977 Amended Schedule of Benefits was approved, "customary" payment levels for each procedure were, in fact, calculated at the 90th percentile of all submitted charges, I find that, in each year since 1977, Blue Shield has limited the allowable percentage increase in "customary" payment levels, in most cases, to an increase less than the rise in the Consumer Price Index. As a result, the "customary" payment levels for a given procedure are now most often lower than the 90th percentile of the submitted "usual charges."

The 1977 Amended Schedule gave Blue Shield the sole authority to determine charge reporting periods used to compute updates of usual and customary charges. Blue Shield has established as its charge reporting period the calendar year preceding each annual July update. For example, the July 1, 1983, update which remains in effect until June 30, 1984, is based on charges submitted during calendar year 1982. As a result, Blue Shield bases its usual and customary payment levels on actual charges that are between 6 and 30 months old.

In each year since 1977, total payments by Blue Shield to participating physicians under the Amended Schedule have been substantially less than the total charges submitted by the doctors. For services rendered by participating physicians to Blue Shield subscribers whose coverage includes the ban on balance billing, the aggregate difference between charges submitted by doctors and Blue Shield payments was $69 million in 1979, $73 million in 1980, $81 million in 1981, $94 million in 1982, and was projected to be $103 million in 1983. The difference between submitted charges and payments, as a percentage of total doctors' charges in Massachusetts, grew from 18.4% in 1976 to 30.7% in 1981, and today remains close to the 30% figure.

I find that Blue Shield has evolved into the single most powerful actor in the various markets for health services in

Massachusetts and that at the present time 99% of the practicing doctors in Massachusetts are Blue Shield participating physicians. I find, in addition, that defendant Blue Shield's 3.2 million subscribers constitute approximately 56% of the population of Commonwealth. Some 2.5 million of those subscribers, or approximately 45% of the total population, have Blue Cross/Blue Shield coverage which is subject to the ban on balance billing.

Moreover, I find that Blue Shield has, by any measure, the dominant market share in the market for prepaid health care in the state. At trial there was voluminous and conflicting testimony as to how best to measure market share in the market for prepaid health care. The Court accepted evidence as to the market share measured by, for example, percentage of population, percentage of privately insured population, percentage of premiums paid, percentage of total health care services expenditures, and percentage of total prepaid health care expenditures. The evidence shows that, as of 1981, Blue Shield and Blue Cross provided coverage for approximately 74% of the privately-insured population in Massachusetts; only 23% of the population had coverage with commercial insurers, and less than 4% of the population was then covered by independent Health Maintenance Organizations (H.M.O.'s).

III. Analysis

The issue before the Court in this case is whether Blue Shield's ban on balance billing constitutes a restraint of trade, monopolization or an attempt to monopolize in violation of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. Section 1 of the Sherman Act of 1890 provides, in pertinent part, that

> [e]very contract, combination ... or conspiracy, in restraint of trade or commerce among the several States, ... is declared to be illegal....

15 U.S.C. § 1 (1973). Section 2 of the Act provides, in relevant part, that

> [e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, . . . shall be deemed guilty of a felony. . . .

15 U.S.C. § 2 (Supp. 1983).

The allegedly anticompetitive effect of conduct challenged under the antitrust laws can be analyzed and evaluated properly only in the context of a well-defined market place. An antitrust plaintiff can make out a prima facie case only upon "proof of a well-defined relevant market upon which the challenged anticompetitive actions . . . have had a substantial impact." *Cornwell Quality Tools Co. v. C.T.S. Co., Inc.*, 446 F.2d 825, 829 (9th Cir. 1971), *cert. denied*, 404 U.S. 1049 (1972). Accordingly, this Court must determine the product market and the geographic market in which the restraint is alleged to have occurred.

In this case, plaintiffs allege that defendants' conduct has had an illegal impact on two distinct geographic and product markets: (1) the market for physicians' services in Massachusetts, and (2) the market for prepaid health care in Massachusetts. I find that the parties are in essential agreement as to the definition of the markets at issue.

I rule that the market for physicians' services consists of doctors licensed in Massachusetts who treat patients on a fee-for-service basis. Doctors in that market provide various services, including surgery, anesthesiology, obstetrics, gynecology, neurology, radiology, internal medicine, and their numerous sub-specialties. Likewise, while some doctors attract patients from outside the state, or from across the state, and others compete in more localized areas, the parties have stipulated, and I find, that the relevant geographic market is the entire state of Massachusetts.

I rule that the market for prepaid health care includes those organizations which provide some form of health care coverage that can be substituted for, and therefore competes with, coverage provided by Blue Cross and Blue Shield of Massachusetts.[11] I find that the relevant product market includes Blue Cross and Blue Shield, commercial insurance companies such as Aetna, Prudential and Travelers, health maintenance organizations (H.M.O.'s), administrative service only companies (ASO's), and employers who self-insure large groups of their own employees. I find, in addition, that it does not include purely governmental programs, like Medicare. I accept the opinion of Dr. Frech, plaintiffs' expert, that the government programs should be excluded from this market because no private company, including Blue Cross/Blue Shield, can effectively offer the same product as, or compete with, the government programs. Moreover, I find that the relevant geographic market for use in evaluating the effect of Blue Shield's practices is the entire state of Massachusetts.

A. Standing

Throughout the course of this litigation defendants have contended consistently that plaintiffs, individually and collectively, lack standing to maintain this antitrust action in each of the relevant markets. Prior to trial, the parties had not developed the record sufficiently to enable the Court to rule whether plaintiffs have antitrust standing. On the basis of the evidence produced at trial, this Court can and will now make that ruling.

Plaintiffs and intervenor-plaintiffs seek injunctive relief under § 16 of the Clayton Act, 15 U.S.C. § 26. Section 16 defines the class of persons who may sue for relief under that section:

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[11] Though plaintiffs steadfastly and pointedly referred throughout the trial to this second market as the "market for private health insurance," their market definition is, in fact, substantially similar to that of defendants, whose nomenclature I now adopt.

> Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief, in any court of the United States having jurisdiction over the parties, against threatened loss or damage by a violation of the antitrust laws, . . . when and under the same conditions and principles as injunctive relief against threatened conduct that will cause loss or damage is granted by courts of equity. . . .

15 U.S.C. § 26 (1973). Read literally, the statute appears to make actionable every harm that can be attributed directly or indirectly to the consequences of an antitrust violation. Yet common sense and *stare decisis* require this Court to take a more restrictive view of standing under § 16.

> [T]he focus of the doctrine of "antitrust standing" is somewhat different from that of standing as a constitutional doctrine. Harm to the antitrust plaintiff is sufficient to satisfy the constitutional standing requirement of injury in fact, but the court must make a further determination whether the plaintiff is a proper party to bring a private antitrust action.

Associated General Contractors of California, Inc. v. California State Council of Carpenters, ____ U.S. ____, 51 U.S.L.W. 4139, 4144 n.31 (U.S. Feb. 22, 1983).

Under § 16, plaintiffs must show "(1) a threatened loss or injury cognizable in equity (2) proximately resulting from the alleged antitrust violation." *City of Rohnert Park v. Harris,* 601 F.2d 1040, 1044 (9th Cir. 1979), *cert. denied,* 455 U.S. 961 (1980). They must also show that the "illegal act is linked to a plaintiff engaged in activities intended to be protected by the antitrust laws." *Reibert v. Atlantic Richfield Co.,* 471 F.2d 727, 731 (10th Cir. 1973), *cert. denied,* 411 U.S. 938 (1973).

Defendants challenge plaintiffs' standing to maintain an action for restraint of trade in the market for prepaid health care, relying primarily on the recent Supreme Court decision

in *Associated General Contractors of California, Inc. v. California State Council of Carpenters*, ___ U.S. ___, 51 U.S.L.W. 4139 (U.S. Feb. 22, 1983). In that case, a carpenters' union alleged that the defendant State Council of Carpenters had restrained trade by coercing general contractors, landowners, and others engaged in construction work to contract with non-union carpenters and firms, thereby reducing the ability of certain unionized firms to compete for those contracts.[12] The Supreme Court rejected the union's claim to standing for a number of reasons which apply in this case.

The Court observed, first, that the central interest of the antitrust laws lies in "protecting the economic freedom of *participants* in the relevant market." *Id.* at 4144 (emphasis added). The Court denied standing to the union in part because if "was neither a consumer nor a competitor in the market in which trade was restrained." *Id.* at 4145. That factor weighs heavily in this case against plaintiffs' claim to standing in the market for prepaid health care because plaintiffs are not consumers or competitors in that market. On the contrary, plaintiffs are contractually involved with defendants only in an altogether different market, the market for physicians' services.

Another factor militates against a finding that plaintiffs have standing in the market for prepaid health care. In *Associated General Contractors* the Supreme Court observed that

> [t]he existence of an identifiable class of persons whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement diminishes the justification for allowing a more remote party such as the Union to perform the office of a private attorney general. Denying the Union a remedy on the basis of its allegations in this case is not likely to leave a significant antitrust violation undetected or unremedied.

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[12] *Associated General Contractors* was an action for damages brought under § 4 of the Clayton Act, 15 U.S.C. § 15. However, the majority of the policy considerations enumerted by the Court are relevant to the present analysis of standing for injunctive relief.

Id. at 4145-46. That reasoning applies squarely in this case. I find that the private insurance companies which compete in Massachusetts in the health care market and whose representatives appeared as witnesses at the trial constitute an identifiable class of persons whose self-interest would obviously motivate them to sue if the alleged violation were to exist in the market for prepaid health care. Moreover, a ruling that denies plaintiffs standing to maintain an action in the market for prepaid health care does not in any way leave a "significant antitrust violation undetected or unremedied." If this Court finds that defendants' conduct in the market for physicians' services violates antitrust laws, plaintiffs will obtain the same relief that they seek for alleged violations in the market for prepaid health care.

Plaintiffs also rely on the 1982 decision of the Supreme Court in *Blue Shield of Virginia v. McCready,* 457 U.S. 465 (1982), to establish their standing to complain of a restraint in the market for prepaid health care. Plaintiffs' reliance on *McCready* is misplaced because of the substantial factual differences between *McCready* and this case. McCready alleged that she was a consumer of psychotherapeutic services and that she had been injured by defendant Blue Shield's conspiracy to restrain competition in the market for such services.[13] Plaintiffs in this case are not consumers in the market for prepaid health care, nor do they sell services in that market. Moreover, the Court in *McCready* noted specifically that while McCready had standing to maintain an action as a consumer market for *psychotherapeutic services,* she did not "allege a restraint in the market for *group health plans.*" *Id.* at 480 (emphasis added).

[13] McCready, a Blue Shield subscriber, alleged that Blue Shield and the Neuropsychiatric Society of Virginia, Inc. had unlawfully conspired to restrain competition in the market for psychotherapeutic services by providing insurance coverage only for consumers who patronized psychiatrists, not psychologists. McCready had obtained services from a psychologist and had been denied reimbursement.

Since the plaintiff physicians in this case participate only as vendors in the *market for physicians' services,* they can only sustain a legally cognizable injury in that market, and can only challenge the ban on balance billing as a restraint in that market. Even if defendants have used illgotten power in the market for prepaid health care as the primary weapon to inflict injury upon plaintiffs as functioning actors in the *market for physicians' services,* that fact does not bestow upon plaintiffs standing to allege a restraint in the market for prepaid health care.

Defendants also argue that plaintiffs lack standing to allege an antitrust violation in the market for physicians' services. The Sherman Act protects the economic freedom of *participants* in the markets where they compete. *See United States v. Topco Associates, Inc.,* 405 U.S. 596 (1972). The doctors sell their services in the market for physicians' services. As vendors in the market for physician' services, they have standing to challenge a restraint of trade in that market. Moreover, the participating physicians also allege that Blue Shield's compensation scheme distorts the market place and has wide-ranging detrimental effects on doctors' freedom and ability to innovate and to engage in non-price competition. Those injuries are certainly "of a type that Congress sought to redress in providing a private remedy for violations of the antitrust laws." *McCready,* 457 U.S. at 483.

Those doctors who have chosen not to sign Participating Physicians' Agreements with Blue Shield have also alleged a legally cognizable antitrust injury. They claim that their refusal to sign the participation agreement effectively precludes them from attracting a large percentage of the state's population as patients. Such a curtailment of competition in the market and refusal to deal would constitute a cognizable antitrust injury. Non-participating doctors are not precluded from bringing suit to restrain the ban on balance billing simply because they refuse to join in the alleged antitrust consipiracy.

B. Plaintiffs' Section 1 Claims

Section 1 of the Sherman Act literally prohibits every contract, combination or conspiracy in restraint of trade. But over the years, courts have read § 1 to prohibit not *every* contract in restraint of trade, but only *unreasonable* restraints of trade. *Standard Oil Co. of New Jersey v. United States,* 221 U.S. 1 (1911); *Chicago Bd. of Trade v. United States,* 246 U.S. 231, 238 (1918). This Court has already ruled that the provider agreements between Blue Shield and participating doctors do not constitute *per se* price-fixing but should be judged under the rule of reason.[14] *Kartell v. Blue Shield of Massachusetts,* 542 F.Supp. at 794. Other courts have almost uniformly applied the rule of reason analysis to similar agreements.[15] *See, e.g., Sausalito Pharmacy, Inc. v. Blue Shield of California,* 544 F.Supp. 230 (N.D. Cal. 1981), *aff'd per curiam,* 677 F.2d 47 (9th Cir. 1982); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut,*

[14] Plaintiffs also allege that Blue Shield and Blue Cross have engaged in a horizontal restraint of trade by their joint medical care certificate and their other marketing agreements and joint administration. M.G.L. c. 176A, § 5 and c. 176B, § 3 expressly authorize Blue Cross and Blue Shield to contract with each other "for the joint administration of their business and for joint and co-operative writing and issuing of certificates." Because any such agreement between Blue Cross and Blue Shield is likely exempt from antitrust scrutiny by virtue of the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq., see, e.g., Quality Auto Body, Inc. v. Allstate Insurance Co.,* 660 F. 2d 1195, 2000-01 (7th Cir. 1981), and by virtue of the state action exemption, *see Parker v. Brown,* 317 U.S. 341 (1943), I analyze only the vertical arrangements between Blue Shield and the individual physicians.

[15] In *Arizona v. Maricopa County Medical Society,* 457 U.S. 332, (1982), the Supreme Court found a similar, but distinguishable, insurance scheme to be a *per se* violation and went on to note that "this case [does not] present the question whether an insurer may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors. That question was not reached in *Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205 (1979)." *Id.* at 353 n.26.

Inc., 675 F.2d 502 (2d Cir. 1982); *Glen Eden Hospital, Inc. v. Blue Cross & Blue Shield of Michigan*, 555 F.Supp. 337 (E.D. Mich. 1983); *Blue Cross & Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980).

Justice Brandeis provided the classic statement of the rule of reason in *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918):

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

The rule of reason requires the fact finder to decide whether under all the circumstances of the case the restrictive practice imposes an *unreasonable* restraint on competition. A restraint is unreasonable if it has the net effect of substantially impeding competition. *See National Society of Professional Engineers v. United States*, 435 U.S. 679, 687-92(1978).

Defendants contend that the special characteristics of the physicians' services market make it inappropriate for the Court to apply traditional antitrust analysis to the ban on balance billing. The fact that the market for physicians' services bears little likeness to the econometric models of "pure competition" does not exempt it from antitrust scrutiny. As the Supreme Court reiterated in *Professional Engineers:*

> The early cases . . . foreclose the argument that because of the special characteristics of a particular industry, monopolistic arrangements will better promote trade and commerce than competition. [Citation omitted]. That kind of argument is properly addressed to Congress and may justify an exemption from the statute for specific industries, but it is not permitted by the Rule of Reason.

Id. at 689-90. Congress has not chosen to exempt the health care industry from the purview of antitrust litigation, and the Supreme Court has been reluctant to create any such exemption. Congress has recently made the "*strengthening of competitive forces* in the health services industry" a matter of national priority and has directed that special consideration be given throughout the planning process to the importance of maintaining and improving competition in the health industry. National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 300k-2(a)(17) (1982) (emphasis added). Moreover, in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the Supreme Court specifically refused to create such a judicial exemption for the physicians' services market. *See id.* at 354-55.

Defendants argue that the ban on balance billing should not be subject to traditional rule of reason analysis for another reason. They claim that the ban on balance billing makes it possible for Blue Cross and Blue Shield to satisfy the strong and otherwise unsated consumer demand for low-cost, comprehensive coverage. It enables Blue Cross and Blue Shield, they argue, to hold down increases in medical costs and, in that way, to minimize increases in subscriber premiums. I rule that, in essence, this is the same argument the Supreme Court rejected summarily in *Maricopa*. The Court of Appeals in that case had upheld the challenged restraint because it served as an effective cost-containment mechanism saving patients and insurers millions of dollars, and because it had facilitated the successful marketing of an attractive insurance plan. *See Arizona v. Maricopa County Medical Socie-*

ty, 643 F.2d 553 (9th Cir. 1980). The Supreme Court rejected that reasoning and found a § 1 violation, calling the test the Court of Appeals had applied "a legal standard based on the reasonableness of the fixed prices, an inquiry [the Supreme Court has] so often condemned." 457 U.S. at 350. Even though a challenged restraint may benefit consumers in the short term, anticompetitive restraints inevitably lessen consumer welfare in the long term. As this Court recently observed in another antitrust case:

> In our economy, ... prices are set by the impersonal forces of competition, and not by consumer preference. Furthermore the law protects the impersonal forces of competition, rather than consumer preference, on the basis that economic forces will ultimately enhance consumer welfare.

M&H Tire Co., Inc. v. Hoosier Racing Tire Corp., 560 F. Supp. 591, 606 (D. Mass. 1983).

I turn now to the very heart of the controversy before this Court: whether the ban on balance billing has the net effect of *promoting or suppressing competition* in the market for physicians' services in Massachusetts. It is defendants' contention not only that plaintiffs have failed to demonstrate any significant harm to competition arising from the ban, but also that the ban has, in fact, numerous procompetitive effects.

Defendants argue that the ban on balance billing *promotes* competition in the market for physicians' services in three ways. First, they contend that, because Blue Cross and Blue Shield provide the inexpensive comprehensive health care coverage which the public demands, they act as entrepreneurial competitors, enhancing, not undermining, the competitive process. But I rule that even if their alleged entrepreneurial activity enhances competition, it does so only in the market for prepaid health care. It does not enhance competition in the market for physicians' services.

Second, defendants argue that the ban on balance billing promotes competition because it protects subscribers from

unrestrained pricing by physicians. Lower prices, in and of themselves, do not necessarily represent enhanced competition, because they can just as easily result from an illegal restraint. Furthermore, as noted above, the fact that "reasonable" fees result from the restraint does not justify an otherwise unlawful restraint of trade. I rule, therefore, that that claim is without legal merit.

Third, defendants argued through the testimony of their expert witness that the ban on balance billing promotes competition becasue it has produced a pricing structure similar to the pricing structure one would expect to find in a market where price competition is widespread. But defendants' expert witness, Dr. Dyckman, conceded that, although he believed that prices now charged by physicians are higher than they should be, he had no idea what a reasonable competitive price would be for any of the thousands of procedures listed in defendants' Basic Benefit Schedule, all of which are subject to the ban. Moreover, I observe once again that, even if reasonable competitive prices could be determined by an individual, by Blue Shield, or by this Court, The reasonableness of a pricing structure engendered by an otherwise unlawful restraint does not justify the restraint.

Finally, it would be inequitable to allow defendants to justify the ban on balance billing as necessary to counter uncompetitively high prices in the market place when defendants themselves caused much of the price inflation in that market through their usual and customary charge method. I find that the usual and customary charge method as originally enacted discouraged participating physicians from reducing prices, or from modifying their fees to reflect actual time and effort expended on a particular patient. If a doctor were to lower prices to some patients, he would lower his "usual charge' profile, thereby reducing the amount Blue Shield would reimburse him in the future. The methodology gave doctors an artificial incentive to develop unrealistically high

charges, in recognition of the fact that their next Level I "usual" profile updates would reflect their higher fees. Defendants acknowledge that Blue Shield adopted the Amended Schedule of Benefits in 1977, with its cap on usual and customary profile updates, in order to break the inflationary spiral of medical costs caused in part by the usual and customary charge method.

To allow defendants unilaterally to impose a "reasonable" price structure in order to counteract high prices which they themselves fostered would surpass the bounds of reason and be abominably bad antitrust law. I find, therefore, that even if it is assumed that the ban on balance billing has some beneficial effects in other areas, it does not *promote competition.*

Defendants also contend that, even if the ban on balance billing constitutes a restraint of trade, it is not an *unlawful* restraint. They rely on the decisions in two recent cases involving similar Blue Cross and Blue Shield provider agreements, *Sausalito Pharmacy, Inc. v. Blue Shield of California,* 544 F.Supp. 230 (N.D. Cal. 1981), *aff'd per curiam,* 677 F.2d 47 (9th Cir. 1982), and *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.,* 675 F.2d 502 (2d Cir. 1982). The Courts in *Sausalito* and *Medical Arts* ruled that contracts between Blue Shield and participating pharmacies do not restrain trade impermissibly unless there is some effect on price formation, or on competitive conduct or conditions, that is independent of what the terms of the contract require. The allegedly illegal restraint in those cases — agreements between sellers and buyers setting a price for fungible goods — was the same "price-fixing" that accompanies every contact. *See Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.,* 441 U.S. 1, 5 (1979). It is defendant's contention that the allegedly anticompetitive effects of the ban on balance billing are directly analogous to the alleged effects which were held not to rise to the level of a Sher-

man Act violation in both *Sausalito* and *Medical Arts*. However, those cases are legally and factually distinguishable from the case at bar.[16]

In both *Sausalito* and *Medical Arts*, plaintiffs challenged the provider agreements solely on the ground that the agreements constituted a price-fixing conspiracy, and were thus *per se* violations of § 1. The courts did not scrutinize the agreements under the rule of reason standard. The plaintiffs in those cases had not alleged, nor had they presented evidence to show, that the agreements had an extra-contractual effect on prices or competition. Because the provider agreements in those cases did not constitute *per se* price-fixing violations, the courts granted summary judgement for the defendants and did not consider whether the agreements violated the rule of reason. Plaintiffs in this case have not only alleged anticompetitive effects that reach beyond the price terms of the provider agreements, but they have presented voluminous evidence in support of their claims.

Moreover, the plaintiff pharmacies in *Sausalito* and *Medical Arts* complained, in effect, simply about the unfavorable terms of contracts into which they had entered

[16] In *Sausalito* and *Medical Arts*, plaintiff pharmacies unsuccessfully challenged provider agreements between themselves and Blue Cross. The agreements between Blue Cross and participating pharmacies established the maximum prices which pharmacies could recover for prescription drugs supplied to Blue Cross subscribers. Under the reimbursement plan examined by the court in *Medical Arts*, which is substantially similar to the provider agreement at issue in Sausalito, Blue Cross subscribers who patronized "participating" pharmacies (*i.e.*, those who had entered into agreements with Blue Cross) were required at most to pay the pharmacy a small "deductible" amount, and the pharmacy was reimbursed by Blue Cross at the rate established in the agreement. Subscribers who patronized non-participating pharmacies paid the pharmacies the over-the-counter prices for prescriptions, and were reimbursed by Blue Cross at the rate established in the subscriber agreement with Blue Cross.

voluntarily. In *Medical Arts*, the district court found specifically that, while the terms of the provider contract were determined unilaterally by Blue Cross, the individual pharmacies did have a meaningful economic choice as to whether or not to sign the contracts.[17] In fact, only 9% of the Connecticut population was eligible for Blue Cross prescription drug benefits, and sales to Blue Cross members amounted to only 9% of the statewide sales volume. 518 F. Supp. 1100, 1103 (D. Conn. 1981). Nothing in the opinion of either the district court or the court of appeals implies that the case would have lent itself to disposition on summary judgment if plaintiffs had been able to show that they were the victims of economic coercion rather than of their own business (mis)judgment. *See Medical Arts*, 675 F.2d at 507; 518 F. Supp. at 1108 n.9.

The facts in this case are substantially different. The testimony at trial establishes, and I find, that under the current Blue Shield payment system, which incorporates the ban on balance billing, Massachusetts physicians have absolutely no meaningful economic choice except to agree to the pricing terms unilaterally established by defendants.[18] Physician participation is not voluntary in any sense of the word, but is, rather, a matter of economic necessity. I find that the fact that over 99% of the state's practicing doctors have signed the participation agreement, and continue to acquiesce in the increasingly restrictive and unfavorable pricing system, proves Blue Shield's economic power, and also proves that there is very heavy economic pressure on doctors to participate.

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[17] The district court's opinion appears at 518 F. Supp. 1100 (D. Conn. 1981).

[18] Plaintiffs acknowledge that defendants, and any other health insurers, are entitled to limit what *they* pay to physicians for medical services rendered to subscribers. Plaintiffs only contest an insurer's right to limit the *total amount* a physician can receive for medical services rendered.

I find that because nearly 60% of all Massachusetts residents subscribe to Blue Cross/Blue Shield, doctors in Massachusetts *must* accept defendants' pricing terms in order to maintain a viable practice in the state. A physician who refuses to participate in the Blue Cross/Blue Shield plan is effectively foreclosed from treating almost two-thirds of the state's residents as patients. By contrast, the Blue Cross plan in *Medical Arts* provided that subscribers would be partially remunerated even for prescriptions filled by non-participating pharmacists. In that way, non-participating pharmacies were not foreclosed completely from dealing with Blue Cross subscribers. Consequently, they had an economically viable, though less lucrative, alternative to participation.

Moreover, while there was conflicting testimony in this case as to the percentage of physician income contingent upon Blue Shield participation, it is clear that a doctor in Massachusetts, when deciding whether or not to sign the participation agreement, must consider factors other than simply the 13-14% of physician practice revenue paid by Blue Shield which is directly derived from services subject to the ban. When Blue Shield payments for services *not* covered by the ban are added in, Blue Shield payments constitute approximately 20% of total physician income. Moreover, I find that participating physicians derive a substantial percentage of their income from out-of-pocket payments by Blue Shield subscribers for non-covered services and from non-subscribers referred to them by other participating physicians. These sources of income are inevitably foreclosed if the doctor decides *not* to sign the participation contract.

In short, I find that Blue Shield "delivers" a much larger percentage of total physician income than the amount of its own payments and I find that its enormous leverage over physicians derives from the amount of physician income it controls.

Drs. Brown, Wilson, Yerkes, Sloss, Rodkey and Kartell testified that it is economically impossible for a non-participating physician to maintain a viable practice in Massachusetts and I so find. In light of that testimony and the particular circumstances of this case, it would be contrary to fact and legally untenable for this Court to find that plaintiffs have *voluntarily* signed the participation agreements, and to rule that they are, therefore, precluded from challenging the allegedly anticompetitive restraint which the contract terms produce.

For the reasons set forth above, I decline to follow the ruling of the courts in *Medical Arts* and *Sausalito.* Yet, the burden of proof set out in those cases remains relevant to this case: plaintiffs must establish that the ban on balance billing has an "effect on price formation, or other type of restraint of trade, independent of what the contract terms . . . require." *Sausalito,* 544 F. Supp. at 235, *quoting Blue Cross & Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics,* 1980-2 Trade Cas. (CCH) ¶63,351 at 75,795 (E.D. Mich. 1980).

In their effort to establish that Blue Shield's current reimbursement system has had, and continues to have, a substantial anticompetitive effect on the market for physicians' services, plaintiffs rely heavily on the 1982 Supreme Court decision in *Arizona v. Maricopa County Medical Society, supra.*[19] This Court is well aware that there are major differences between the Blue Shield system incorporating the ban on balance billing that is under consideration in this case and the insurance plan which the Supreme Court found to be *per se* violative of the Sherman Act in *Maricopa.* Nevertheless, I rule that the legal and economic principles underlying the decision in *Maricopa* may be appropriately applied to the controversy now before this Court.

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[19] This Court considers itself bound by the decision in *Maricopa,* but notes that Justices O'Connor and Blackmun recused themselves and that Chief Justice Burger and Justices Powell and Rhenquist dissented. How the Supreme Court would rule on this same issue in the next case to come before it is anyone's guess.

In *Maricopa*, the Supreme Court examined a maximum fee arrangement that was substantially similar to the Blue Shield system which plaintiffs now challenge. The defendant in that case, the Maricopa County Medical Society, established the Maricopa Foundation for Medical Care, a non-profit corporation composed of approximately 70% of the doctors engaged in private practice in Maricopa County, Arizona. The foundation, by agreement of its member doctors, established a schedule of maximum fees that participating doctors agreed to accept as payment in full for services performed for patients insured under plans approved by the foundation. A patient who was insured by a foundation-endorsed plan was guaranteed complete coverage if he or she was treated by a foundation member; if the doctor's bill exceeded the foundation's maximum fee, the foundation disallowed the excess pursuant to the doctor's membership agreement.[20] The patient was free to go to a nonmember physician and was covered for charges that did not exceed the fee schedule. He was, however, liable for any amount in excess of the foundation payment. Participating doctors were free to charge higher fees to uninsured patients than they charged to insured patients and they were also permitted to charge any patient less than the schedule maximum. Seven insurance companies, representing a maximum of 63% of the prepaid health care market, underwrote health plans approved by the foundation. 457 U.S. at 341 n.11.

Certainly, the most significant difference between the plan struck down in *Maricopa* and the Blue Shield plan currently

[20] The physicians' agreement in *Maricopa* provided in part that the physician agreed "to be bound ... with respect to maximum fees ... by any fee determination by the [f]oundation consistent with the schedule adopted by the [foundation physician] membership...." The agreement also provided that foundation members "understand and agree that participating membership in the [f]oundation shall not affect the method of computation or amount of fees billed by [the physician] with respect to any medical care for any patient." 457 U.S. at 359 (Powell, J., dissenting).

under challenge in this case is that the maximum price levels in *Maricopa* were fixed by the doctors themselves, rather than by a medical service corporation like Blue Shield. The restraint in *Maricopa* was thus a classic example of a horizontal maximum price-fixing agreement between competitors. Accordingly, the Supreme Court struck down the agreement under the *per se* rule against price-fixing. *Id.* at 348.

The mere fact that the Blue Shield plan in this case does not constitute *per se* horizontal price-fixing does not make its adverse impact on competition any less objectionable than the plan struck down by the Supreme Court in *Maricopa*.[21] The determinative factor in any § 1 analysis is the impact, or the probable impact, of a restraint on competition, not the means employed to effect that impact.

When the Supreme Court reversed the Court of Appeals for the Ninth Circuit in *Maricopa* and ruled that the maximum fee arrangements, as price-fixing agreements, were *per se* unlawful under § 1 of the Sherman Act, the Court was

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[21] In *Maricopa*, the Court reflected on the procedural aspects of the creation of a fee schedule, and noted that an insurer, such as Blue Shield, is itself capable of creating a fee schedule through altogether different means:

> In order to create an insurance plan under which the doctor would agree to accept as full payment a fee prescribed in a fixed schedule, someone must canvass the doctors to determine what maximum prices would be high enough to attract sufficient numbers of individual doctors to sign up but low enough to make the insurance plan competitive. In this case that canvassing function is performed by the foundation; the foundation then deals with the insurer. It would seem that an insurer could simply bypass the foundation by performing the canvassing function and dealing with the doctors itself. Under the foundation plan, each doctor must look at the maximum-fee schedule fixed by his competitors and vote for or against approval of the plan (and, if the plan is approved by majority vote, he must continue or revoke his foundation membership). A similar, if to some extent more protracted, process would occur if it were each insurer that offered the maximum-fee schedule to each doctor. *Id.* at 353-4 n.28.

concerned primarily with the restraint's anticompetitive impact on the market for physicians' services and the resultant long-term negative effect on the quality and availability of health care. Justice Stevens, writing for the Court, observed:

> In this case the rule is violated by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs. It may be a masquerade for an agreement to fix uniform prices, or it may in the future take on that character. 457 U.S. at 348.

Indeed, many of these anticompetitive effects have materialized in the present case. As the Blue Shield methodology has evolved away from the unrestricted usual and customary charge method incorporating the ban, the restrictive effect of the ban on balance billing has become more pronounced. I find that the evidence establishes that over the last six years, since the adoption of the Amended Schedule of Benefits, defendants have limited the annual percentage increases in the "customary" (or Level II) charges, with the result that the usual and customary charge methodology has taken on many of the functional attributes of a fee schedule system.[22] The percentage of claims paid at the "customary" level (Level II) fixed by Blue Shield, rather than at either the "usual charge" level (Level I), or the submitted charge level, has increased significantly. In fiscal year 1980, approximately 35% of all claims for services were paid at Level II rates; in 1981 that percentage increased to nearly 40%, and in fiscal year 1982, approximately 46% of all claims were paid at the "customary" level as adjusted by Blue Shield.

[22] Internal Blue Shield memoranda show that the purpose of the compression of the Level I and Level II fees is to produce a fee schedule for Blue Shield payments. *See, e.g.*, Plaintiffs' Exhibit 45.

Thus I find that, in effect, Blue Shield has converted its usual and customary charge methodology into a fee schedule system with all of the operational characteristics and competitive effects associated with such a system.

As the Supreme Court predicted in *Maricopa*, those doctors in Massachusetts wanting to compete by offering innovative or "premium" services — services requiring more of the doctors' time and expense — are discouraged from doing so because defendants' pricing structure presumes that doctors' services are fungible. Defendant Blue Shield pays all doctors at the same "customary" maximum price level regardless of their levels of skill, their experience, their levels of training, their willingness to employ new procedures, or the levels of care they provide. Thus, the Blue Shield maximum fee system permits no financial reward for excellence, nor does it provide an incentive for individual qualitative improvement or innovation.

Dr. Frech testified that the Blue Shield system makes a physician's total income dependent almost entirely on volume — the number of procedures performed — rather than on the time and effort expended in the care of a particular patient. Dr. Frech's observation is corroborated by the experience of Dr. Henry Brown, a Massachusetts physician who is one of the plaintiffs in this case. Dr. Brown's experience provides an example of how the Blue Shield system produces the harmful effects envisioned by the Supreme Court in *Maricopa*.

I find that Dr. Brown is a surgeon who has been associated with the Harvard Surgical Services at Boston City Hospital since 1963, and is the head of the Hand Teaching Service at Harvard. Dr. Brown became a Blue Shield participating physician in 1963, and remained one until 1978 when he resigned rather than bow to the above-mentioned pressures to increase his patient load and compromise the quality of care provided. Following his resignation, Dr. Brown found that he was unable to maintain a viable practice in Massachu-

setts: when prospective patients learned that Blue Shield would neither pay Dr. Brown directly, since he was no longer a participating physician, nor reimburse the patients directly for services rendered by him, "the great majority of them felt that they had paid their premiums, and [they] would go to another physician." Thus, following his resignation from Blue Shield, Dr. Brown determined that to survive economically he had to shift the emphasis of his practice to out-of-state patients.

I find that Dr. Brown now maintains a small private practice in Massachusetts, while serving as Chief of the Hand Clinic and Director of Rehabilitation Medicine at the Veterans Administration Hospital in Manchester, New Hampshire, and that, at the present time, only 20% of Dr. Brown's income is derived from services provided to Massachusetts residents on a fee-for-service basis. I find that not only has Dr. Brown's freedom to compete in the market for physicians' services in Massachusetts been adversely affected, but also that his services are less available to Massachusetts residents, subscribers and non-subscribers alike, as a direct result of the Blue Shield plan.

Similarly, as the Court in *Maricopa* predicted, the ban on balance billing has had the effect of discouraging innovation, and of discouraging the development and application of new medical procedures in Massachusetts. The testimony of Dr. Stephen Hedburg illustrates how the Blue Shield plan discourages both innovations in, and the widespread adoption of, new medical techniques. Dr. Hedburg is a Blue Shield participating physician, specializing in surgery and clinical endoscopy at Massachusetts General Hospital. In addition, he serves as a clinical professor of surgery at Harvard Medical School. Dr. Hedburg testified that in the early 1970's he was one of the first doctors in the country, and the first doctor in Massachusetts, to perform a new procedure known as "colon-

oscopy with polypectomy."[23] I find that this outpatient procedure had a significantly lower cost, required much less in-hospital time, and involved much less risk to the patient, than the traditional surgical alternative which requires hospitalization and a much greater out-of-pocket expense.[24]

In 1974, when Dr. Hedburg's average charge for the colonoscopy with polypectomy was $500, the average Blue Shield reimbursement for the procedure was $170. At the same time, Dr. Hedburg received for the identical procedure an average of $175 from Medicare, $245 from Medicare with complimentary, and $425 from other sources. The gap has since narrowed. Dr. Hedburg currently charges around $800 and Blue Shield pays close to $700. The out-of-pocket cost for the traditional surgical alternative is now approximately $6,000.

It is axiomatic that neither Dr. Hedburg nor any other doctor has an inalienable right to receive his asking price for this procedure, or for any other procedure, nor do the antitrust laws protect any particular level of doctor compensation. However, the antitrust laws are intended to preserve and foster incentives to compete and to innovate. Blue Shield's reluctance to provide full remuneration for innovative procedures, coupled with its ban on balance billing, discourages physicians from undertaking the training and purchasing the equipment necessary to learn and offer the safer, innovative, relatively inexpensive procedure.[25] As a result, doctors in

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[23] A colonoscopy is a form of endoscopy in which the interior of the colon is examined using a colonoscope, a flexible fiberoptic instrument approximately six feet in length, which is introduced into the colon. The endoscopist is able to examine the lining of the colon in great detail and is capable of using the same instrument to perform biopsies and other surgical procedures within the colon. The removal of a benign tumor is called a polypectomy.

[24] The true economic cost of the procedure also includes wages foregone by a patient during the longer hospitalization and recovery.

[25] Defendants claim that the low initial level of payment by Blue Shield was due to an insufficiency of fee data and to incorrect fil-

Massachusetts have been reluctant to learn the new colonoscopy with polypectomy procedure. It is likely that, for those persons contemplating surgery in the early 1970's, including both Blue Shield members and nonmembers, the new procedure, with its many advantages, was a less available and less attractive medical alternative than it might have been had competitive market forces not been restrained.

While the parties have stipulated that the ban on balance billing has had no impact on *average* physician practice income, I find that the Blue Shield payment scheme "tends to provide the same economic rewards to all practitioners regardless of their skills, their experience, [or] their training," *Maricopa*, 457 U.S. at 348, and I find that the result of such a plan is that, in Massachusetts, superior physicians are undercompensated and below-average physicians are overcompensated.

Moreover, Blue Shield deters above-average or experienced doctors from entering the market for physicians' services in Massachusetts through its policy regarding compensation of "new" doctors. No matter how many years an experienced doctor has been in practice in a state outside of Massachusetts, and no matter how high the doctor's level of skill and experience, the maximum amount Blue Shield will pay any doctor in his first year of practice in Massachusetts is limited to the 50th percentile of the "customary charges" for that

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ings by physicians. Further, they argue that the initial interim fee established by Blue Shield's fee committee, though perhaps too low, was nonetheless reasonable. Both of these arguments miss the point. The crucial point in plaintiffs' argument is not that Blue Shield's fee determination was ultimately unreasonable (though it may have been), but that the low initial fee, in conjunction with the ban, in fact deterred physician adoption of the new procedure. Precisely because a low fee determination by Blue Shield, even if made in good faith, can have these deleterious effects, it is especially important that during the early, formative development of a medical technique, the market, not Blue Shield, should determine the relative value of a procedure.

procedure. Massachusetts may in fact be insulated from the immediate effects of such a disincentive, for many superior doctors are no doubt willing to forego some financial rewards in order to practice in the Boston area with its high caliber medical personnel, and its world-renowned teaching hospitals and facilities. Nevertheless, I find that, while there has not been a decrease in the total number of doctors practicing in the Commonwealth, the Blue Shield plan as it presently exists tends to make Massachusetts a less attractive place to practice medicine than it would be absent the ban on balance billing.

Plaintiffs contend, but failed to prove, that the current Blue Shield payment plan has caused an exodus of practicing physicians from Massachusetts. Data received in evidence from the American Medical Association, from Blue Shield, and from the Massachusetts Medical Society, a plaintiff in this case, show, and I find, that there has not been a substantial migration of physicians out of Massachusetts. Rather, I find that the number of practicing physicians in Massachusetts has increased steadily during the past decade.

The policy considerations which the Supreme Court found to be persuasive in *Maricopa* are even more compelling on the markedly different factual record of this case. The Supreme Court in *Maricopa*, even while recognizing the voluntary and non-binding nature of the physicians' participating in the foundation, held that the plan had a disturbing tendency to stifle medical innovation and to deter the investment of extra time and money on the part of physicians, to the ultimate detriment of quality health care. Those same policy concerns can only be heightened in this case by the fact that physician participation in the Blue Shield plan is not, in fact, voluntary. I find that resignation is not a viable alternative for Massachusetts physicians who believe that the Blue Shield Participating Physicians' Agreement inhibits their offering innovative or more time-consuming health care.

Another important difference between the two cases is that in *Maricopa* the Supreme Court was concerned with the economic effects of a plan covering 70% of the practicing physicians in *one county* in Arizona. In this case, participation is statewide and the restraint is thus more pervasive. Over 99% of the practicing physicians in the Commonwealth are bound by the price restrictions promulgated by Blue Shield. If a prospective patient living in Maricopa County, Arizona has been dissatisfied with the level or quality of care provided by the 70% of the doctors in the county who were members of the foundation, he was able either to turn to one of the 30% of the doctors in Maricopa County who were not members of the foundation or to a doctor in another county. A similarly dissatisfied prospective patient in Massachusetts must look to a doctor in another state, an unlikely eventuality, or turn to one of the very few non-participating physicians in Massachusetts. Thus, the impact of the illegal restraint in *Maricopa* was much more limited than the impact which is generated by the Blue Shield plan now under attack, both in terms of the adverse impact on patients' choice of doctor and the effect on competition among doctors in general.

Defendants seek to counter plaintiffs' reliance on *Maricopa* with two arguments. First, they argue that the Blue Shield plan, incorporating the ban on balance billing, has no anti-competitive effect on competition in the physicians' services market because doctors remain free to charge any fee that they wish. On this record, however, that argument is misleading and factually incorrect. Certainly, doctors remain able to announce any fee level they choose. But for services rendered to a majority of the state's population the ban on balance billing prevents them from collecting more than the amount Blue Shield is willing to pay on behalf of its subscribers. The economic freedom protected by the Sherman Act is not the meaningless freedom simply to ask for any particular fee, but rather the fundamental freedom to bar-

gain for, and to receive, a market-determined price for services rendered.

Moreover, defendants' argument rests on the notion that Blue Shield does not set physicians' fees, but merely establishes the levels at which it will pay doctors for services rendered to its subscribers. That distinction was implicitly rejected by the Supreme Court in *Maricopa*. In that case, participating doctors agreed to a schedule of maximum fees which they would accept as payment in full for health services provided to certain policyholders, although they specifically retained the "right" to charge a patient any fee of their choosing.[26] Despite the explicit contractual disclaimer stating that the agreement did not restrict the pricing freedom of any of the foundation's member doctors, the Supreme Court characterized the maximum fee arrangement as one which regulated *prices* and price competition.

Second, defendants argue that because Blue Shield's payments subject to the ban on balance billing constitute only 13-35% of total physician revenue, Blue Shield's payments affect too small a proportion of total physician revenue to enable it to exert control over prices in the market for physicians' services. It is not, however, plaintiffs' burden to establish that Blue Shield has absolute control over pricing in the market for physicians' services. Instead, plaintiffs allege, and I rule that they have in fact proved, that Blue Shield's current system tends to distort, eliminate, and impede price competition among physicians. The Supreme Court has long held that inability to *control* prices does not save an otherwise illegal scheme.

> Any combination which tampers with price structures is engaged in an unlawful activity. Even though the members of the price-fixing group were in no position to control the market, to the extent that they raised, lowered, or stablilized prices they would be directly interfering with the free play of market forces.

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[26] See Footnote Number 20, *supra*, for the exact wording of the contract.

United States v. Socony-Vacuum Oil Co., Inc., 310 U.S. 150, 221 (1940). Since I find that defendants' usual and customary charge method, as applied together with the ban on balance billing, has the effect of fixing prices in the market for physicians' services and of otherwise interfering with the free play of market forces, I rule that it violates § 1 of the Sherman Act. The testimony at trial establishes, and I find, that Blue Shield plans which incorporate the ban on balance billing substantially reduce the level of price competition in the market for physicians' services in Massachusetts.

In summary, I rule that defendants' ban on balance billing imposes an unreasonable restraint on competition in the market for physicians' services in Massachusetts. I find that the restraint has a deleterious effect on competition in that market far exceeding the mere diminution in doctors' earnings that results directly from the terms of the Participating Physicians' Agreement. I find further that this effect is not offset by any demonstrable procompetitive effect. The ban interferes substantially with doctor's basic freedom and ability to compete — to offer a variety of medical services to the public in return for a price determined by market forces. As predicted by the Supreme court in *Maricopa*, the restraint has had, and continues to have, the effect of discouraging innovation and of discouraging the adoption of new medical techniques. In addition, I find that the ban reduces the quality of medical care in Massachusetts because it suppresses the normal market-generated incentives for physicians to improve and refine their services. For these reasons, I rule that the ban on balance billing unreasonably restrains trade in the market for physicians' services in Massachusetts in violation of Section 1 of the Sherman Act and that its further implementation should be enjoined.

C. Plaintiffs' Section 2 Claims

In light of this Court's disposition of plaintiffs' claim under § 1 of the Sherman Act, and further, because plaintiffs pray

for identical relief under § 2 of the Act, I do not believe a lengthy analysis of the merits of the remaining Section 2 claim is warranted. Succinctly stated, I find plaintiffs have not sustained their burden of proving that Blue Shield has monopolized the market for physicians' services in Massachusetts.

Order accordingly.

Andrew A. Caffrey, Ch. J.

Appendix C

United States Court of Appeals For The First Circuit

No. 84-1241

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASS., INC.,
Defendant, Appellant.

No. 84-1290

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASS., INC., ET AL.,
Defendants, Appellees.

MASSACHUSETTS MEDICAL SOCIETY, ET AL.,
Intervenors/Plaintiffs, Appellants.

No. 84-1303

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASS., INC., ET AL.,
Defendants, Appellees.

COMMISSIONER OF INSURANCE,
Intervenors/Defendant, Appellant.

JUDGMENT

Entered: November 28, 1984

These causes came on to be heard on appeals from the United States District Court for the District of Massachusetts, and were argued by counsel.

Upon Consideration whereof, It is now here ordered, adjudged and decreed as follows: The district court's finding that the ban on balance billing is unlawful is reversed, and the district court's injunction is vacated. In all other respects the order of the district court is affirmed. No Costs.

By the Court:

FRANCIS P. SCIGLIANO, Clerk.

By Janice M. O'Neil
Supervisory Deputy.

[cc: Messrs. Witherby, Fremont-Smith,
Springer and Mahoney.]

Appendix D

United States District Court
District of Massachusetts

Civil Action
No. 78-594-C

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET. AL.,
Defendants.

ORDER

March 19, 1984

CAFFREY, Ch. J.

In accordance with opinion filed this date, it is ORDERED:

1. Blue Shield is enjoined from implementing the so-called ban on balance billing effective as of the first day of the month following that in which this judgment becomes final.
2. Complaint dismissed as to Blue Cross.

Andrew A. Caffrey, Ch. J.

United States District Court
District of Massachusetts

Civil Action
No. 78-594-C

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET. AL.,
Defendant.

AMENDED ORDER

March 22, 1984

CAFFREY, Ch. J.

The Order entered herein on March 19, 1984 is amended to add a third paragraph thereto so that the order will read:

In accordance with opinion filed March 19, 1984, it is ORDERED:

1. Blue Shield is enjoined from implementing the so-called ban on balance billing effective as of the first day of the month following that in which this judgment becomes final.
2. Complaint dismissed as to Blue Cross.
3. Complaint dismissed as to the Massachusetts Commissioner of Insurance, intervenor-defendant.

Andrew A. Caffrey, Ch. J.

MOTION FILED
MAR 25

(3) (3)

Nos. 84-1353, 84-1354

Office-Supreme Court, U.S.
FILED
MAR 25 1985
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

JAMES P. KARTELL, HERBERT W. HORNE, JR. and HARRY D. WILSON, JR.,

Petitioners,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,

Respondent.

GRANT V. RODKEY, M.D., HENRY BROWN, M.D., and THE MASSACHUSETTS MEDICAL SOCIETY,

Petitioners,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,

Respondent.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

MOTION OF AMERICAN MEDICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONERS

Of Counsel:
KIRK B. JOHNSON
B. J. ANDERSON
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5000

NEWTON N. MINOW
JACK R. BIERIG*
JEFFREY R. TONE
Sidley & Austin
One First National Plaza
Chicago, Illinois 60603
(312) 853-7000

Counsel for Amicus Curiae American Medical Association
* Counsel of Record

March 25, 1985

24 pp

Nos. 84-1353, 84-1354

IN THE

Supreme Court of the United States

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Respondent.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

MOTION OF AMERICAN MEDICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

The American Medical Association respectfully requests that it be granted leave to file a brief amicus curiae in support of petitioners. The brief is submitted herewith.

In support of this motion, the Association states as follows:

1. Consent was sought from petitioners and respondent for the filing of a brief amicus curiae in support of petitioners. Petitioners consented, but respondent did not. A copy of petitioners' letters of consent is reproduced in the Appendix to the Brief Amicus Curiae.

2. The Association is the oldest and largest national organization of physicians in the United States. It had 254,000 physician members at the end of 1983.

3. Many of the Association's members in Massachusetts are directly affected by the ban on balance billing at issue in this case.

4. If the decision of the Court of Appeals is allowed to stand, these physicians will be victims of a practice which, as the district court found, discourages the use of "the safer, innovative, relatively inexpensive procedure." *Kartell* v. *Blue Shield of Massachusetts*, 582 F. Supp. 734, 752-53 (D. Mass.), *aff'd in part, rev'd in part and vacated in part*, 749 F.2d 922 (1st Cir. 1984). In addition, the First Circuit's decision has significance beyond Massachusetts. If that decision is not reversed, other Blue Shield plans in other states will be encouraged to impose similar bans—with similar adverse effects.

5. Furthermore, the decision of the Court of Appeals has nationwide ramifications with respect to the antitrust significance of other cost-control mechanisms introduced by insurers. These mechanisms will have a direct impact on the members of the Association.

6. As a national organization dedicated to fostering the advancement of medical science and the health of the American people, the Association offers an important perspective on the issues before the Court. The Association

therefore submits its brief amicus curiae in order to present its thoughts on why the decision of the Court of Appeals does not permit proper scrutiny of the competitive significance of the challenged ban. The Association also seeks to explain why the ban suppresses competition and why its elimination will promote competition, enhance consumer welfare, and encourage innovation and good medical care.

CONCLUSION

The Association respectfully requests that this Court grant it leave to file the brief amicus curiae submitted herewith.

Respectfully submitted,

NEWTON N. MINOW
JACK R. BIERIG
JEFFREY R. TONE
SIDLEY & AUSTIN
One First National Plaza
Chicago, Illinois 60603
(312) 853-7000
Counsel for Amicus Curiae American Medical Association

Of Counsel:
KIRK B. JOHNSON
B. J. ANDERSON
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5000

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Nos. 84-1353, 84-1354

IN THE

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Respondent.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF OF AMERICAN MEDICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS CURIAE

This brief is submitted by the American Medical Association in support of petitioners.[1] Founded in 1846, the

[1] The filing of this brief was consented to by all petitioners but not by respondent. A copy of petitioners' letters of consent is reproduced in the Appendix hereto. In accordance with Supreme Court Rule 36, this brief is submitted with the Motion of American Medical Association for Leave to File Brief Amicus Curiae.

Association is the oldest and largest national organization of physicians in the United States. At the end of 1983, it was comprised of over 254,000 physicians.

The Association and its members have a direct interest in the issues raised by petitioners. Initially, many of the Association's members in Massachusetts are immediately affected by respondent Blue Shield's ban on balance billing. If the decision of the Court of Appeals is allowed to stand, these physicians will be victims of a practice which discourages them "from undertaking the training and purchasing the equipment necessary to learn and offer the safer, innovative, relatively inexpensive procedure." *Kartell v. Blue Shield of Massachusetts*, 582 F. Supp. 734, 752-53 (D. Mass.), *aff'd in part, rev'd in part and vacated in part*, 749 F.2d 922 (1st Cir. 1984).

More generally, the First Circuit's decision in this case has significance beyond Massachusetts. If the decision is not reversed, Blue Shield plans in other states will be encouraged to impose similar bans—at least where they have sufficient market power to do so. Thus, the adverse effects on competition and on quality of care found by the district court will spread to other states.

Finally, the decision has nationwide ramifications in a number of different contexts not directly related to a ban on balance billing. As pressures to reduce health care costs intensify, insurers throughout the country can be expected to introduce a variety of cost-control mechanisms. These mechanisims will have a major effect on the delivery of medical care by physicians. Some of these mechanisms, *e.g.*, preferred provider organizations (PPOs), are generally pro-competitive.[2] Others, *e.g.*, PPOs with market dominance

[2] In a PPO, the insurer and provider agree on the maximum charge that the provider will make to PPO subscribers. In return, the insurer offers financial incentives to induce patients to use the "preferred provider." Most PPOs also have effective programs of utilization review.

and exclusivity agreements, may be anti-competitive. *See Jefferson Parish Hospital District No. 2* v. *Hyde*, —— U.S. ——, 104 S.Ct. 1551 (1984).

Under the decision of the Court of Appeals, these cost-control mechanisms will be virtually immunized from anti-trust scrutiny regardless of their competitive significance. They will be justified simply because they are imposed by an insurer who is viewed as a purchaser of services. The effect of this development will be to permit anticompetitive conduct that leads to inferior medical care.

As a national organization dedicated to fostering the advancement of medical science and the health of the American people, the Association offers an important perspective on the issues before the Court. It respectfully submits this brief amicus curiae in order to present its thoughts on why the decision of the Court of Appeals does not permit proper scrutiny of the competitive significance of the challenged ban and of other restraints imposed by insurers. The Association also seeks to explain why the ban on balance billing suppresses competition and why elimination of the ban will promote competition and enhance consumer welfare.

Specifically, giving physicians the freedom to choose whether to accept an insurer's coverage as full payment for services promotes competition among physicians on the basis of price. This freedom will ultimately reduce the cost of health care. It will, moreover, enable physicians who do not accept the insurer's award as full payment to compete on the basis of quality of service. Thus it will encourage innovation and good medical care.

STATEMENT OF THE CASE

At issue in this case is Blue Shield's practice of prohibiting physicians from collecting the difference between their actual charge for a procedure and the amount reimbursed by Blue Shield for that procedure. As both lower courts agreed, the facts relating to this "ban on balance billing" are " 'not . . . generally . . . disputed.' " Petitioners' Appendix at 4 (hereinafter cited as "App."). These facts are set forth in detail in the two petitions.

In essence, however, the relevant facts can be reduced to five basic points:

1. Blue Shield of Massachusetts, Inc. is a medical service corporation which dominates the market for health insurance in Massachusetts. Blue Shield insures 3.2 million people, roughly 56 percent of the population of the Commonwealth and nearly three quarters of the privately insured population. The Court of Appeals stated that it "assume[d] that Blue Shield possesses significant market power." App. 11.

2. Blue Shield makes no payment for services performed by a physician who does not participate in its plan—except for emergency or out-of-state services. Notably, Blue Shield of Massachusetts is virtually unique among Blue Shield plans in the United States in this respect.

3. Blue Shield's dominant market share and refusal to pay for the services of non-participating physicians combine to force Massachusetts physicians to participate in the Blue Shield plan. The district court found that "doctors must accept defendants' pricing terms in order to maintain a viable practice . . . " 582 F. Supp. at 749. Not surprisingly, therefore, 99 percent of Massachusetts physicians in fee-for-service practice participate in the Blue Shield plan.

4. By virtue of payment practices adopted in 1977, the amounts paid by Blue Shield to participating physicians are substantially lower than physicians'

charges. In 1983, the difference between Blue Shield payments and the charges submitted by physicians was 103 million.

5. Blue Shield prohibits participating physicians from charging patients the difference between the actual charge for a procedure and the amount paid by Blue Shield. Thus, every physician must accept as payment in full the amount paid by Blue Shield. The physician is foreclosed from billing the patient for the balance of his or her charge even though this balance might reflect a difference in skill, experience, or accessibility.

The Court of Appeals did not disturb the district court's findings with respect to any of these facts. Rather, it held that on these facts, there was no "restraint" at all. App. 5. It concluded that "[t]he persuasive power of the district court's analysis disappears . . . once one looks at Blue Shield, not as an inhibitory 'third force' but as itself the purchaser of the doctors' services." App. 6. Viewing Blue Shield as merely a buyer, the Court held that the ban on balance billing is presumptively valid, because "[a]ntitrust law rarely stops the buyer of a service from trying to determine the price or the characteristics of the product that will be sold." Id.

The Court then considered whether Blue Shield's "significant market power" should rebut the presumption that its actions as a buyer are valid. App. 10. It concluded that Blue Shield's market power makes no "significant legal difference" at least as long as the insurer's prices are "below incremental cost." App. 11-12. In support of this conclusion, the Court cited no precedent dealing with section 1. Instead, it relied exclusively on monopolization cases under section 2 of the Sherman Act.

Having already concluded that the ban on balance billing is not a restraint at all, the Court turned to the specific

anticompetitive effects of the ban. It summarily dismissed these effects by observing that, as a buyer, Blue Shield can pay whatever it chooses for physicians' services. It then went on to consider various public policy arguments which it regarded as militating in favor of the ban. App. 18-20.

REASONS FOR GRANTING THE PETITION

I. THE DECISION OF THE COURT OF APPEALS CONFLICTS WITH EVERY DECISION OF THIS COURT WHICH HAS SET FORTH THE PROPER ANALYSIS UNDER THE RULE OF REASON.

The decision of the Court of Appeals conflicts directly and fundamentally with an unbroken line of cases which sets forth the proper analysis under the Rule of Reason. *National Collegiate Athletic Association* v. *Board of Regents*, ___ U.S. ___, 104 S.Ct. 2948, 2982 (1984); *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 691 (1978); *Continental T.V. Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36, 49 (1977); *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 238 (1918). These cases uniformly teach that "the inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition." *Professional Engineers, supra*, 435 U.S. at 691. In undertaking this inquiry, a court must consider "the facts peculiar to the business, the history of the restraint and the reasons why it was imposed." *Id.* at 692. *See also Copperweld Corp.* v. *Independence Tube Corp.*, ___ U.S. ___, 104 S. Ct. 2731, 2741 (1984) (The Rule of Reason mandates "an inquiry into market power and market structure designed to assess . . . actual effect" on competition); *Board of Trade, supra*, 246 U.S. at 238 (A court must consider "the nature of the restraint and its effect, actual or probable").

Under the Rule of Reason, the "purpose of the analysis is to form a judgment about the competitive significance of the restraint." *Professional Engineers, supra*, 435 U.S. at

692. The Court of Appeals, however, did not even attempt to analyze the competitive significance of the challenged ban on balance billing. It made no effort to evaluate the competitive effects of the ban in light of Blue Shield's market dominance and other facts peculiar to the delivery of physicians' services in Massachusetts. Rather, as far as the Court of Appeals was concerned, "[t]he relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge." App. 10. It would be difficult to imagine a clearer deviation from the inquiry into competitive effects mandated by relevant precedent of this Court.

The Court of Appeals considered itself free to dispense with any analysis of the competitive significance of the challenged restraint based entirely on its conclusion that Blue Shield was "the purchaser of the doctors' services." App. 6. The conclusion that Blue Shield is a buyer of services led the Court to make no assessment of the impact of Blue Shield's market power on competitive conditions—as required by *Copperweld, Professional Engineers,* and similar cases. Instead, the Court confined its consideration of Blue Shield's market dominance to an abstract discussion of whether a buyer's market power can overcome the presumption that the buyer may determine the price or characteristics of the product that will be sold.

For the same reason, the Court of Appeals dismissed in a single sentence petitioners' contentions regarding the anticompetitive nature of the challenged ban. Specifically, petitioners argued that, given Blue Shield's market dominance, the ban virtually eliminated price competition among physicians, reduced competition on the basis of quality, and discouraged market entry by new physicians. App. 15. Even though the district court had found these arguments dispositive, the entire "analysis" by the Court of Appeals was as follows: "The short—and conclusive—answer to these

arguments is that normally the choice of what to seek to buy and what to offer to pay is the buyer's." App. 16.

In short, the Court of Appeals substituted application of the "purchaser" label for analysis of competitive significance. Nothing in section 1 of the Sherman Act, however, permits justification of challenged conduct on the basis of defendant's status rather than inquiry into the competitive effects of defendant's conduct. On the contrary, after *Professional Engineers, Board of Trade,* and similar cases, the "purchaser" label should be of little relevance for purposes of Section 1 analysis.[3] Indeed, this Court has carefully scrutinized the competitive effects of purchase contracts. *See, e.g., Fortner Enterprises, Inc.* v. *United States Steel Corp.,* 394 U.S. 495 (1969); *Tampa Electric Co.* v. *Nashville Coal Co.,* 365 U.S. 320 (1961).

Antitrust claims should not be determined on the basis of an "'artificial distinction' at the expense of substance." *Copperweld, supra,* 104 S.Ct. at 2743. Any departure from the Rule of Reason should be "based upon demonstrable economic effect rather than . . . upon formalistic line drawing." *Sylvania, supra,* 433 U.S. at 58-59. Under the Rule of Reason, the question remains "whether or not

[3] In any event, reliance on the "purchaser" label as the basis of decision is particularly inappropriate on the facts of this case. It is, of course, true that Blue Shield indemnifies the patient for physicians' fees. But it is the patient who selects the physician, who agrees with the physician on the nature and extent of services performed, and who benefits from the treatment. Moreover, Blue Shield's contract with insureds provides that nothing therein shall "interfere with the normal relationship that exists in the community between a physician . . . and his patient." Thus, the First Circuit's characterization of Blue Shield as the purchaser of physicians' services is highly questionable. At most, it is accurate only to a point. In these circumstances, invocation of the "purchaser" label confounds rather than enlightens.

the challenged restraint enhances competition." *NCAA*, *supra*, 104 S.Ct. at 2982—not whether or not the defendant can be viewed as a purchaser.

In this respect, it is noteworthy that the only Supreme Court precedent cited by the Court of Appeals in support of its point that Blue Shield is a purchaser of services was *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.*, 440 U.S. 205, 214 (1979). Significantly, *Royal Drug* did not involve a Rule of Reason analysis at all. Rather, the question before this Court was whether certain "Pharmacy Agreements" were immune from antitrust scrutiny by virtue of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1013, which exempts from Section 1 of the Sherman Act the state-regulated business of insurance.[4] In determing whether the Pharmacy Agreements constituted the "business of insurance," this Court looked to whether they involved "any underwriting or spreading of risk" or were "merely arrangements for the purchase of goods and services by Blue Shield." *Id.* at 214.

The Court concluded that, as "arrangements for the purchase of goods and services," the Pharmacy Agreements were not the "business of insurance" and therefore were not immune from Sherman Act scrutiny. The Court did not, however, analyze those Agreements under the Sherman Act. In fact, it explicitly noted that the question whether the Pharmacy Agreements violated the antitrust laws was not presented. *Id.* at 210, n.5. In sum, *Royal Drug* provides no authority for the First Circuit's conclusion that under Section 1 of the Sherman Act, Blue Shield's supposed status as a buyer obviates the need for a searching inquiry into the competitive significance of its conduct.

[4] Under the Pharmacy Agreements, participating pharmacies agreed to receive as full payment from Blue Shield their actual acquisition cost of a drug, plus a $2 markup. 440 U.S. at 209.

Similarly, the Court of Appeals' reliance on lower court cases is also misplaced. The First Circuit relied primarily on *Quality Auto Body, Inc.* v. *Allstate Insurance Co.*, 660 F.2d 1195, 1203 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982); *Travelers Insurance Company* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80, 84 (3rd Cir.), *cert. denied*, 414 U.S. 1093 (1973); and *Medical Arts Pharmacy of Stamford, Inc.* v. *Blue Shield of Connecticut, Inc.*, 518 F. Supp. 1100 (D. Conn. 1981), *aff'd per curiam*, 675 F.2d 502 (2d Cir. 1982). In none of those cases, however, did the courts hold that the agreements at issue were lawful because the insurers were merely purchasers.

Rather, each court applied the Rlue of Reason and concluded that the plaintiffs had failed to prove any anticompetitive effect of the plan beyond a reduction of the provider's profits. *See, e.g., Medical Arts, supra*, 675 F.2d at 505 ("Blue Cross pharmacy agreements are novel restraints with potential procompetitive effects, and therefore must be analyzed under the Rule of Reason.")[5] Thus, the Court of Appeals' rejection of the Rule of Reason analysis in favor of a presumption of validity for the ban on balance billing is without any precedential support whatsoever.

II. BY FAILING TO CONDUCT THE REQUIRED ANALYSIS OF THE COMPETITIVE EFFECTS OF THE BAN ON BALANCE BILLING, THE COURT UPHELD A RESTRAINT VIOLATIVE OF THE ANTITRUST LAWS.

The ban on balance billing suppresses competition by restraining both price and output. *See NCAA, supra*, 104

[5] Indeed, the *Medical Arts* court indicated Blue Cross was more properly characterized as an indemnitor rather than as a purchaser and also indicated that the precise characterization was not important to the proper application of the antitrust laws. 675 F.2d at 505-06.

S.Ct. at 2982. Because Blue Shield's subscribers have no out-of-pocket expense, the ban eliminates any sensitivity to price by these subscribers. Consequently, physicians who would otherwise compete on the basis of price have little incentive to do so. In addition, the ban restrains price competition because a physician may raise his or her charges without any penalty imposed by the market.[6]

Furthermore, the ban has had an adverse effect on output —in terms of both quality of patient care and development of new procedures. The ban discourages competition on the basis of quality because the artificially low pricing does not permit the market to reward superiority in skill, experience, or compassion. Moreover, the record reveals very negative effects on innovation. Specifically, development of new procedures that are highly beneficial to patients is discouraged by Blue Shield's policies.

The anticompetitive effects of the ban are inescapable given Blue Shield's domination of the market and its requirement that physicians participate in the plan if any payment is to be made for their services. Absent Blue Shield's market dominance, physicians would be free to reject Blue Shield's strictures. Alternatively, if non-participating physicians received Blue Shield payments, they could treat subscribers and bill them for the difference between the Blue Shield allowable payment and the physician's actual charge. In either case, there would be competition on the basis of price, quality, service and innovation.

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[6] Although the ban precludes such an increase from resulting in any immediate gain to the physician, the increase can have long-term benefits because increased charges will raise the "usual" charge screen applicable to an individual physician or the "customary" charge level of physicians in the aggregate, thereby increasing Blue Shield's payments.

In light of Blue Shield's market dominance and payment practices, however, physicians in Massachusetts are forced to accept the ban on balance billing. Thus, competition among physicians on the basis of price and quality is inevitably suppressed. In any event, the First Circuit foreclosed an analysis of the competitive effects of the ban by concluding that, as a buyer, Blue Shield did not impose a restraint at all.

CONCLUSION

For the foregoing reasons, the Petitions for a Writ of Certiorari should be granted.

Respectfully submitted,

Newton N. Minow
Jack R. Bierig
Jeffrey R. Tone
Sidley & Austin
One First National Plaza
Chicago, Illinois 60603
(312) 853-7000

Counsel for Amicus Curiae American Medical Association

Of Counsel:

Kirk B. Johnson
B. J. Anderson
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
(312) 645-5000

February 19, 1985

Jack R. Bierig, Esq.
Sidley & Austin
One First National Plaza
Chicago, IL 60603

Re: *Kartell, et al.* v. *Blue Shield of Massachusetts, Inc.*, et al. (1st Cir.)

Dear Mr. Bierig:

On behalf of Drs. Kartell, Horne and Wilson (the original plaintiffs), I hereby consent to the filing by the American Medical Association of a brief *amicus curiae* supporting the grant of a writ of certiorari in this case.

Yours very truly,

JAMES VAN R. SPRINGER

Enclosure

February 19, 1985

Jack R. Bierig, Esq.
Sidley & Austin
One First National Plaza
Chicago, IL 60603

Re: *Kartell* v. *Blue Shield*
(1st Cir. Nos. 84-1241, 84-1303)

Dear Mr. Bierig:

On behalf of the intervenor-plaintiffs, I hereby consent to the filing by the American Medical Association of a brief *amicus curiae* in support of a petition for certiorari.

Sincerely,

THAYER FREMONT-SMITH

MOTION
MAR 25 1985

No. 84-1353

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

JAMES P. KARTELL, HERBERT W. HORNE, JR.
and HARRY D. WILSON, JR.,
Petitioners,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,
Respondent.

MOTION FOR LEAVE TO FILE AND BRIEF OF BALL MEMORIAL HOSPITAL INC., *et al.* *AMICUS CURIAE* SUPPORTING THE PETITION FOR WRIT OF *CERTIORARI* TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

DOUGLAS B. MCFADDEN
(Counsel of Record)
JOHN A. BORSARI
DAVID M. HALBREICH
MICHAEL I. ENDLER
DUTTON & OVERMAN
2000 M. Street, N.W., Suite 260
Washington, D.C. 20036
(202) 293-0700

REX P. KILLIAN
HALL, RENDER, KILLIAN,
HEATH & LYMAN
3921 N. Meridian Street,
Suite 200
Indianapolis, Indiana 46208

Attorneys for Ball Memorial Hospital, Inc. et al.

March 25, 1985

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

No. 84-1353

JAMES P. KARTELL, HERBERT W. HORNE, JR.
and HARRY D. WILSON, JR.,
Petitioners,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,
Respondent.

MOTION OF BALL MEMORIAL HOSPITAL INC., *ET AL.* FOR LEAVE TO FILE BRIEF OF AN *AMICUS CURIAE*

Applicants, by their attorneys, do hereby respectfully request permission for leave to file a brief *amicus curiae* in the above captioned proceeding. In support thereof, the following is shown:

1. Applicants, 40 Indiana hospitals, are presently involved in pending litigation against Blue Cross and Blue Shield of Indiana (hereinafter "BCBSI").[1]

2. Applicants, as members of the health care community, have a great interest in the outcome of the *Kartell* proceeding. Given that the First Circuit's opinion is drafted in all encompassing language, its holding in *Kartell* promises to have significant impact beyond the parties to

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[1] Applicants are 40 of 80 Indiana hospitals who are plaintiffs in *Ball Memorial Hospital, Inc., et al. v. Mutual Hospital Insurance, Inc., d/b/a Blue Cross of Indiana, and Mutual Medical Insurance, Inc. d/b/a Blue Shield of Indiana*, No. IP-84-1536-C (S.D. Ind.). See appendix attached hereto.

this litigation and effect the other members of the health care industry whose economic interests were not represented in that case, nor likely even contemplated. Therefore, the disposition of the petition for *certiorari* will have a far reaching impact on the entire health care industry nationwide.

3. Due to the fact that *Kartell* will have an impact on the entire health care industry, it is important that a variety of members of the health care industry be heard on the legal issues raised in *Kartell.* While the Petitioners have done a commendable job in briefing this Court, it is respectfully submitted that other members of the health care community, such as Applicant hospitals, could aid this Court in its analysis of the issues in this case.

4. In reversing the District Court's ruling in *Kartell,* the Circuit court found that Blue Shield is merely a purchaser of services. (A6)[2] This finding has an impact on future cases involving not only Section One of the Sherman Act, but also Section Two (15 U.S.C. §§ 1 or 2). The legal issues of monopsony power and Section Two of the Sherman Act were not fully addressed by the Petitioners and will be further analyzed by Applicants in their brief.

5. In conclusion, Applicants believe there are important legal issues which will not be fully addressed by the parties in this proceeding. Accordingly, it is respectfully submitted that the significance of the legal issues and the impact of this case on the health care industry in this country merits granting of the filing of Applicants' brief.

---

[2] Petitioners' Appendix to its Petition For Certiorari will be cited herein as "A ___."

WHEREFORE, it is respectfully requested that Applicants be granted leave to file a brief *amicus curiae*.[3]

Respectfully submitted,

DOUGLAS B. MCFADDEN
(Counsel of Record)
JOHN A. BORSARI
DAVID M. HALBREICH
MICHAEL I. ENDLER
DUTTON AND OVERMAN
2000 M. Street, N.W., Suite 260
Washington, D.C. 20036
(202) 293-0700

REX P. KILLIAN
HALL, RENDER, KILLIAN,
HEATH & LYMAN
3921 N. Meridian Street
Suite 200
Indianapolis, Indiana 46208

Attorneys for Ball Memorial Hospital Inc., et al.

[3] Counsel for Petitioners gave their consent to the filing of this *Amicus* Brief. Counsel for the Massachusetts Medical Society, *et. al.* consented to the filing of this Brief. Counsel for Respondents was contacted but would not consent to the filing of this Brief. Counsel for the Massachusetts Commissioner of Insurance consented to the filing of this Brief.

APPENDIX OF *AMICUS CURIAE*

BALL MEMORIAL HOSPITAL, INC.

CAYLOR-NICKEL HOSPITAL, INC.

DEACONESS HOSPITAL, INC.

ELKHART GENERAL HOSPITAL

GOSHEN HOSPITAL ASSOCIATION, INC., d/b/a GOSHEN GENERAL HOSPITAL

KING'S DAUGHTERS' HOSPITAL

LAFAYETTE HOME HOSPITAL, INC.

MARION GENERAL HOSPITAL

MEMORIAL HOSPITAL OF FLOYD COUNTY

MEMORIAL HOSPITAL OF MICHIGAN CITY

MEMORIAL HOSPITAL OF SOUTH BEND, INC.

MERCY HOSPITAL, INC.

METHODIST HOSPITAL OF INDIANA, INC.

OUR LADY OF MERCY HOSPITAL

SOUTH BEND OSTEOPATHIC HOSPITAL

ST. CATHERINE HOSPITAL OF EAST CHICAGO, INDIANA, INC.

ST. JOSEPH MEMORIAL HOSPITAL OF KOKOMO, INC.

ST. JOSEPH'S HOSPITAL (FORT WAYNE)

ST. JOSEPH'S MEDICAL CENTER

ST. MARGARET HOSPITAL

ST. MARY MEDICAL CENTER, INC. (GARY)

ST. MARY'S MEDICAL CENTER OF EVANSVILLE, INC.

TERRE HAUTE REGIONAL HOSPITAL

WESTVIEW HOSPITAL

THE BOARD OF TRUSTEES OF BLACKFORD COUNTY HOSPITAL

THE BOARD OF TRUSTEES OF CLINTON COUNTY HOSPITAL

THE BOARD OF TRUSTEES OF DAVIESS COUNTY HOSPITAL

THE BOARD OF TRUSTEES OF DECATUR COUNTY MEMORIAL HOSPITAL

THE BOARD OF TRUSTEES OF GOOD SAMARITAN HOSPITAL

THE BOARD OF TRUSTEES OF GREENE COUNTY GENERAL HOSPITAL

THE BOARD OF TRUSTEES OF HANCOCK MEMORIAL HOSPITAL

THE BOARD OF TRUSTEES OF HARRISON COUNTY HOSPITAL

THE BOARD OF TRUSTEES OF HENRY COUNTY MEMORIAL HOSPITAL

THE BOARD OF TRUSTEES OF HUNTINGTON MEMORIAL HOSPITAL

THE BOARD OF TRUSTEES OF JOHNSON COUNTY MEMORIAL HOSPITAL

THE BOARD OF TRUSTEES OF PUTNAM COUNTY HOSPITAL

THE BOARD OF TRUSTEES OF RIVERVIEW HOSPITAL

THE BOARD OF TRUSTEES OF STARKE MEMORIAL HOSPITAL

THE BOARD OF TRUSTEES OF TIPTON COUNTY MEMORIAL HOSPITAL

THE BOARD OF TRUSTEES OF WITHAM MEMORIAL HOSPITAL

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DOUGLAS B. MCFADDEN
(Counsel of Record)
JOHN A. BORSARI
DAVID M. HALBREICH
MICHAEL I. ENDLER
DUTTON & OVERMAN
2000 M. Street, N.W., Suite 260
Washington, D.C. 20036
(202) 293-0700

REX P. KILLIAN
HALL, RENDER, KILLIAN,
HEATH & LYMAN
3921 N. Meridian Street,
Suite 200
Indianapolis, Indiana 46208

Attorneys for Ball Memorial Hospital, Inc. et al.

March 25, 1985

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INTEREST OF THE AMICUS CURIAE

Amicus Curiae is comprised of forty out of one hundred and fifteen acute care hospitals in the State of Indiana, ranging from primary care community hospitals to tertiary care referral centers. As integral members of the health care industry in this country, hospitals generally have a fundamental interest in any decision before this Court which has the potential for addressing the dynamic relationships between the components of the health care community from an antitrust perspective. The manifest involvement of the hospitals now before this Court with these issues is evidenced by forty of the eighty being

parties plaintiff in *Ball Memorial Hospital, Inc., et al. v. Mutual Hospital Insurance, Inc., d/b/a Blue Cross of Indiana, and Mutual Medical Insurance, Inc. d/b/a Blue Shield of Indiana,* No. IP-84-1536-C (S.D. Ind.).

The First Circuit's ruling in *Kartell* has the potential for drastically affecting the health care industry. Even though the case dealt solely with agreements between an insurer and physicians, it promises to have impact upon all areas of health care given its all encompassing language and its failure to differentiate between the various segments of the health care industry. *Amicus Curiae* wishes to aid this Court in its decision as to whether *certiorari* should be granted by framing the issues from the hospitals' vantage point. Given that the hospitals are the other major branch of health care service providers in this country, it would be in the public interest for this Court to make its decision informed as to all the possible ramifications surrounding an issue of paramount national significance.

QUESTION PRESENTED [1]

Whether the Court of Appeals correctly held that provider contracts by which a market-dominant health insurer imposes a maximum fee schedule upon physicians are categorically lawful under Sherman Act 1, without evaluation under the rule of reason and notwithstanding the District Court's undisturbed findings, after trial, that the contracts unreasonably restrain competition in the relevant geographic market for physicians' services.[1]

---

[1] The Question Presented is taken from the Petition for Writ of Certiorari to the United States Court of Appeals for the First Circuit filed by James P. Kartell, *et al.* at page i. Petitioners' Appendix to its Petition For Certiorari will be cited herein as "A ___."

SUMMARY OF ARGUMENT

Issues raised by the petition for writ of certiorari have the potential for affecting the entire health care industry throughout this country. Given the likely fallout from the Court of Appeals' decision, it is essential that any case of this magnitude by adjudicated within the confines of traditional antitrust law and be decided after input from other major actors in the health care market. These actors, such as the hospitals comprising *amicus curiae* will certainly feel the consequences of this case although their dynamic role in the marketplace was not considered either by the parties or the courts below. Unless *certiorari* is granted, ambiguous signals regarding the application of the antitrust laws to the health care industry will be transmitted due to the new trails blazed by the First Circuit. Guidance is necessary from this Court to reaffirm that the antitrust laws apply with full force and effect to the health care industry, that the only consideration relevant to the evaluation of a restraint of trade is its effect on competition, that a provider agreement, like any other agreement, is not *per se* lawful and must be scrutinized under the rule of reason, and that monopsony power must be constrained when it is used to maintain or extend monopoly power. Only through this guidance can the health care industry continue to benefit from enhanced competition unencumbered by an otherwise strong tendency to limit the free play of market forces.

I. This Case Should Be Heard Because it Presents Unique Policy Questions Which Are Contrary to Traditional Antitrust Analysis And Are Of Paramount Importance To The Health Care Industry.

A. The Health Care Industry Is Subject to the Same Scope of Antitrust Scrutiny as any Other Industry.

In terms of the Sherman Act's (15 U.S.C. 1 *et seq.*) fundamental concern with the promotion of competition, which has long been recognized by this Court, *Chicago Board of Trade v. United States,* 246 U.S. 231, 238 (1918), that absent statutory direction from Congress no more dangerous assault upon the free exchange of market forces exists than for the courts to distinguish between different industries and accord

some industries preferential treatment under the antitrust laws. Unfortunately, the Court of Appeals has given undue consideration to factors beyond competition, practically tantamount to an exemption, primarily because the validity of the restraints it was asked to rule upon arise in the health care field. In two different sections of its opinion, the court emphasized its hesitancy to apply traditional antitrust analysis to the health care field.[2] While the Circuit Court's concern over the health care industry may be justified, it has no place in a traditional antitrust analysis. In *National Society of Professional Engineers v. United States,* 435 U.S. 679 (1978) this Court held that a rule of reason "inquiry is confined to a consideration of impact on competitive conditions." *Id.* at 690. At this point in time, neither Congress nor the courts have provided for an exemption to the health care industry from the antitrust laws. Nowhere was this principle more forcefully stated than in *Arizona v. Maricopa County Medical Society,* 457 U.S. 322 (1982), where this Court held an agreement among competing physicians to be *per se* unlawful under Section One of the Sherman Act. The fact that doctors—rather than non-professionals—were the parties to the price fixing agreement was irrelevant.

The Court stated:

> We are equally unpersuaded by the argument that we should not apply the *per se* rule in this case because the judiciary has little antitrust experience in the health care industry. The argument quite obviously is inconsistent with *Socony-Vacuum.* In unequivocal terms, we stated that, "[w]hatever may be its peculiar problems and characteristics, the Sherman Act, so far as price fixing agreements are concerned, establishes one uniform rule applicable to

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[2] "The rising costs of medical care, the possibility that patients cannot readily evaluate (as competitive buyers) competing offers of medical service, the desirability of lowering insurance costs and premiums, the availability of state regulation to prevent abuse—all convince us that we ought not create new potentially far-reaching law on the subject." (A14) The court later stated that "the subject matter of the present agreement—medical costs—is an area of great complexity where more than solely economic values are at stake." (A19)

> all industries alike." 310 U.S., at 222. We also stated that "[t]he elimination of so-called competitive evils [in an industry] is no legal justification for price-fixing agreements, *Id.*, at 220 . . ."

Id. at 349.

The Court of Appeals' special tolerance for restraints of trade imposed in the health care field is therefore completely at odds with the decisions of this Court and the well accepted intent of the Sherman Act. By transmitting a signal to the health care community that such restraints will be granted special judicial leniency, if not exempted from challenge entirely, then an industry which is finally entering a competitively driven phase will have no incentive to do so; the impact of cases like *Maricopa* and *National Society of Professional Engineers* will be lost.

Ironically, even though the Court of Appeals was concerned about creating "far-reaching" law, its departure from a traditional rule of reason analysis may reach much farther than it could have anticipated. If the petition for writ of *certiorari* is not granted and the First Circuit's ruling remains intact, the entire health care industry could be drastically affected. Until such time as Congress determines to act upon these issues, the courts should continue a traditional rule of reason analysis.

B. Social Welfare Is An Impermissible Basis to Decide Antitrust Cases.

The Court of Appeals was greatly concerned with the rising costs of health care and the resulting effects on the public. This Court has time and time again rejected precisely this same type of argument. In *National Society of Professional Engineers, supra,* the National Society of Professional Engineers argued that its restraint on bidding on engineering services served to protect the public by preventing the production of inferior work. Justice Stevens, writing for the Court, rejected this argument, stating,

> It is this restraint that must be justified under the Rule of Reason, and petitioner's attempt to do so on

> the basis of the potential threat that competition poses to the public safety and the ethics of its profession is nothing less than a frontal assault on the basic policy of the Sherman Act.

Id. at 695.

The policy argument raised by the Petitioners and rejected by the Court in *National Society of Professional Engineers* is indistinguishable from the Court of Appeals' reliance on public interest concerns in *Kartell.* The only difference is that, in *National Society* this Court chose to ignore these concerns whereas the *Kartell* Court based its decision upon them.

The First Circuit in *Kartell* also placed emphasis on the fact that not only was it analyzing medical costs, but the costs at issue were low costs, not high ones. (A18-19). While the argument that lower costs are in the public benefit is appealing at first blush, an analysis of antitrust precedent leads to a wholly different result. In *Arizona v. Maricopa County Medical Society, supra,* this Court held that the mere fact that the "price restraint will make it easier for customers to pay does not distinguish the medical profession from any other provider of goods or services." *Id.* at 349. This Court went on to reject the position of Blue Shield and the Court of Appeals, i.e., that extracting lower prices enhances competition:

> We do not perceive the respondents' claim of procompetitive justification for their fee schedules to rest on the premise that the fee schedules actually reduce medical fees and accordingly reduce insurance premiums, thereby enhancing competition in the health insurance industry. Such an argument would merely restate the long rejected position that fixed prices are reasonable if they are lower than free competition would yield.

Id. at 352, n.25.

The competitive evil of artificially lowering costs has been addressed in a variety of factual circumstances much as *Arizona v. Maricopa County Medical Society, supra,* wherein a horizontal agreement between doctors to fix maximum prices was held *per se* unlawful under Section One of the Sherman Act. Similarly, in *Albrecht v. Herald Co.,* 390 U.S. 145 (1968) an Agreement

to fix maximum resale prices was held to be a *per se* violation of Section One of the Sherman Act. This Court there rejected the notion that "a price ceiling was necessary to protect the public from price gouging by dealers . . ." *Id.* at 153. Furthermore, this Court has long held that a buyer's use of monopsony power to obtain lower costs than its competitors is violative of Section Two of the Sherman Act. *Mandeville Island Farms v. American Crystal Sugar Co.*, 334 U.S. 219 (1948)

These cases are in striking contrast to the Court of Appeals' reliance on the fact that it was dealing with low prices rather than high prices. The First Circuit's rationale is therefore contrary to decades of antitrust precedent of this Court.

Finally, the fact that Blue Shield may have good intentions in that it allegedly is attempting to keep health care costs down is of little importance in an antitrust analysis. In *N.C.A.A. v. Board of Regents of the University of Oklahoma*, this Court stated that it is "well-settled that good motives will not validate an otherwise anticompetitive practice."[3] The contention that Blue Shield is promoting lower health care costs and benefiting the public is of no import where the method it utilizes to bring about this end has anticompetitive effects.

II. THE COURT OF APPEALS HAS IMPERMISSIBLY CREATED AN IRREBUTTABLE PRESUMPTION OF LEGALITY WHENEVER PROVIDER AGREEMENTS ARE IN ISSUE.

The central issue on appeal embraced by the parties and both courts below is whether an agreement between an insurer and a provider of health care services (hereinafter referred to as a provider agreement) can violate the Sherman Act by containing terms and conditions which unreasonably restrain trade.[4] In analyzing this issue the Court of Appeals took a markedly different approach than the District Court. Leaving

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[3] 104 S.Ct. 2948, 2960, n. 23 (1984).

[4] Although Section Two of the Sherman Act was tangentially touched upon in both decisions below, the Section Two argument was treated in summary fashion and did not play any role in either court's analysis.

the District Court's Findings of Fact in place, the First Circuit focused solely on whether Blue Shield was a purchaser of physicians' services. To the Court of Appeals, the only "relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge." (A10).

The First Circuit opinion is therefore a tautology. The Court of Appeals reversed the District Court because the First Circuit believed there can be no restraint of trade, no "third force intervening in the marketplace", (A6) when Blue Shield is characterized as a purchaser. Thus, without inquiry into the competitive consequences of the restraint in issue the First Circuit has established a standard of *per se* lawfulness for all restraints imposed by "purchasers" on their sellers.

The importance of the First Circuit's decision cannot be overstated. With one fell swoop this decision has eliminated the rule of reason from Section One analysis, let alone the relevance of market power in that analysis, (*See* A11), whenever the term in question arises out of the relationship between buyers and sellers. At the same time, the First Circuit has eliminated Section Two as an alternative cause of action in this context. The court stated, "whether or not that price bargain is, in fact, reasonable is, legally speaking, beside the point even in the case of a monopolist . . . We can find no relevant analytical distinction between this type of purchasing decision and the practice before us even on the assumption that Blue Shield possesses market power." (A14) While professing a reluctance to blaze new trails, (A19) the First Circuit without any economic analysis has effectively excluded provider agreements from the reach of the antitrust laws.

From a policy perspective, this decision has dramatic and far reaching implications. There is a constant tension between providers of health care services on the one hand and purchasers, such as insurers, on the other. This tension is coming to a peak for hospitals across the country with a movement away from traditional methods of health care financing and health care delivery systems towards various alternative delivery systems. One such system is generically known as a preferred provider organization. Depending on who sponsors the system,

hospitals are either asked or coerced to submit bids to become "preferred providers" at a discount from their prevailing charges. In return the sponsor promises to shift its insureds away from those hospitals which did not bid or were not selected and to steer them to those "preferred hospitals". Insureds are motivated to utilize "preferred" hospitals by linking complete insurance coverage to the selection of a "preferred" hospital. If a non-preferred hospital is utilized, the insured will likely have to cover some, if not all of the expenses.

While the emergence of these systems is generally procompetitive, these arrangements, like any other lawful device, are susceptible to abuse. Indeed the potential for abuse is great in that these alternative delivery systems are being brought to market by all types of new entrants, particularly the health care providers themselves, including the hospitals. The traditionally dominant forces in the health care insurance market are quite sensitive to the small in-roads these systems have made. The hospitals before this Court as *amicus curiae*, representative of hospitals throughout the country, are concerned by the First Circuit's limitation of both sections of the Sherman Act to redress these abuses as they arise.

If this Court denies *certiorari*, then the availability of an antitrust remedy to cure competitive evils in the health care insurance market and services markets will be greatly undermined, severely prejudicing atomistic groups like the physicians in the case *sub judice* or the hospitals whose financial viability is continually threatened by overcapacity. Only by hearing this case can this Court address the First Circuit's broad brushed disposition of provider agreements and provide guidance for the lower courts as to how provider agreements in all their possible formulations should be governed by the antitrust laws.

III. THIS COURT SHOULD GRANT CERTIORARI TO CLARIFY WHETHER ITS PREVIOUS DECISIONS EXCLUDE PROVIDER AGREEMENTS FROM TRADITIONAL ANTITRUST ANALYSIS.

The Court of Appeals reversed the District Court because the conduct complained of related to Blue Shield's position as a purchaser of physician services. The First Circuit's reasoning

rests strictly on a statement in *Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979):

> The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield.

440 U.S. at 214 (*cited* in *Kartell* at A6).

This Court in *Royal Drug* expressly stated that the only issue before the Court was "whether the Court of Appeals was correct in concluding that these Pharmacy Agreements are not the 'business of insurance' within the meaning of Section 2(b) of the McCarran-Ferguson Act." *Id.* at 210. That the lower courts have nonetheless seized upon *Royal Drug* as substantive authority for upholding provider agreements is particularly incomprehensible given the Court's further statement that "[w]hether the Agreements are *illegal* under the antitrust laws is an entirely separate question, not now before us." *Id.* (emphasis in original, footnote omitted).

As if these explicit statements were not enough, in *Arizona v. Maricopa County Medical Society, supra,* this Court expressly left open consideration of the issues presented by this case. The Court there stated:

> Nor does this case present the question of whether an insurer may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors. That question was not reached in *Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

Id. at 353 n. 26.

Despite this Court's consistent statements that the issue now before it was not being decided, some lower courts, especially, the First Circuit in *Kartell,* adopted the *Royal Drug* language and transferred it into a conclusive presumption. Despite the recognized judicial reluctance to allow mere labels to be outcome determinative, *United States v. Masonite Corp.*, 316 U.S. 265, 280 (1952), *Simpson v. Union Oil Co.*, 377 U.S.

13 (1964), the categorization of a contract as one between buyers and sellers has achieved exactly that—the label dictates the result.[8]

IV. THE FIRST CIRCUIT STRAYED FROM TRADITIONAL SECTION ONE ANALYSIS BY COMPLETELY IGNORING THE RULE OF REASON IN ESTABLISHING A STANDARD OF *PER SE* LEGALITY.

Just as this Court has early on recognized that Congress would not have intended a literal interpretation of the word "every" in analyzing restraints under Section One, *Standard Oil Co. of New Jersey v. United States*, 221 U.S. 1 (1911), this Court has implicitly recognized that Congress could not have intended that entire segments of the economy, in this case provider agreements, be deemed *per se* lawful and the rule of reason abandoned. Indeed, in *Norfolk Monument Co. v. Woodlawn Memorial Gardens, Inc., et al*, 394 U.S. 700 (1969) (per curiam) this Court reversed the grant of summary judgment for defendants after extensive pretrial discovery. The Court stated that "[t]he reasonableness of the rules was a material question of fact whose resolution was the function of the jury and not of the court on a motion for summary judgment." *Id.* at 702-703.

Norfolk Monument is particularly applicable to the case at bar because the Court of Appeals reversed a District Court which was most familiar with the facts in dispute after having

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[8] In the past, even where the label was not *per se* determinative of the result, the Court of Appeals as in *Quality Auto Body, Inc. v. Allstate Insurance Co.*, 660 F.2d 1195 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982) affirmed the District Court's incorporation of the rule of reason in upholding the restraint. Thus where plaintiffs have plead more than a *per se* violation provider agreements have been upheld only after judicial scrutiny of the particular restraint in issue. Even in the arena of non-price vertical restraints, which have routinely been upheld, this Court has held that the rule of reason is still applicable. *See, Continental of Virginia, Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977). At the very least there is a dramatic conflict between the Circuits, but in all likelihood, the First Circuit's reversal without any rule of reason analysis is unsupported by the caselaw.

sat for 37 days, heard 38 witnesses, reviewed 281 exhibits and issued a 55 page decision condemning the restraint.[6]

Even if Blue Shield is deemed a buyer, that categorization is beside the point. The District Court's decision condemning the restraint did not turn on the wooden distinction raised by the First Circuit as to the relationship between the parties. Whether Blue Shield purchases services, or reimburses its insureds for the same, the District Court found no procompetitive justification for the restraint. (*See* A52). Just as importantly, the court found many anticompetitive effects accompanying the restraint. Labeling Blue Shield as a buyer does not make these effects disappear; consumers are left with the burdens imposed by the restraint resulting from treating physicians services as fungible. As the District Court aptly pointed out, the evil of the price fixing scheme in *Maricopa* was present with full force and effect in the case at bar, especially since the District Court found that Blue Shield's "usual and customary" fee methodology has been converted into a fee schedule with operational and competitive characteristics associated with such a system. (*See* A59-60).

This Court identified those evils as follows:

> In this case the rule is violated by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs. It may be a masquerade for an agreement to fix uniform prices, or it may in the future take on that character.

Maricopa, 457 U.S. at 348.

The District Court on the other hand adhered to the classic formulation of the rule of reason laid down by this Court in

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[6] *See* Petition For Writ of Certiorari filed by Grant V. Rodkey, M.D., Henry Brown, M.D. and the Massachusetts Medical Society on February 25, 1985 in Docket 84-1354 at p. 4.

Chicago Board of Trade v. United States, supra, which was cited with approval in *Maricopa:*[7]

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied. . . . The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts.

246 U.S. at 238.

The inquiry under the above formulation is couched in mandatory terms: "The court must ordinarily consider." The District Court, not the Court of Appeals, followed this mandate and considered facts peculiar to the industry. The District Court, not the Court of Appeals, considered the history of the restraint. The District Court, not the Court of Appeals, considered the evil believed to exist, the reason for adopting the remedy and the end sought. Thus the District Court's conclusion is no different from the other cases cited by the Court of Appeals which had considered the merits under a full rule of reason formulation.[8] It is in fact the Court of Appeals, which having totally ignored the requisite rule of reason analysis, has strayed far afield of the inquiry this Court mandates in sanctioning these restraints.[9] In light of this radical departure from traditional antitrust analysis, this Court should grant the petition for *certiorari* to redress this error.

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[7] *Maricopa,* 457 U.S. at 343 n. 13.

[8] That the other cases reached different conclusions regarding the provider agreements before them is not surprising given that, as this Court has recognized, the rule of reason is based on the facts of each particular case and little guidance should be expected from one case to another. *Maricopa* at 343.

[9] As noted above the Court of Appeals considered matters of social welfare and Blue Shield's good motives in upholding the restraint. This analysis is markedly contrary to mainstream antitrust inquiry, *N.C.A.A., supra,* being a recent example. There the Court stated, "[b]oth *per se* rules and the rule of reason are employed 'to form a judgment about the competitive significance of the restraint.'" *Id.* at 2962, *citing National Society of Professional Engineers v. United States,* 435 U.S. 679, 692 (1978).

V. ERRONEOUS ASSUMPTIONS REGARDING THE INTERPLAY OF MARKET POWER IN THE CONTEXT OF SECTION ONE PORTEND TO HAVE UNWARRANTED IMPACT IN THE CONTEXT OF SECTION TWO.

A. The First Circuit's Decision Should Be Evaluated Against The Broader Context of the Entire Health Care Industry.

The First Circuit's reasoning regarding the importance of market power exacerbates the nature of its errors, for this case promises to go far beyond being viewed as a Section One case and will likely have unfortunate fallout in terms of Section Two. This spillover no doubt will stem from the Court of Appeals' statement that "even a monopolist is free to exploit whatever market power it may possess when that exploitation takes the form of charging uncompetitive prices" so long as the price was not predatory, i.e. "below incremental cost". (*See* A12).[10] This statement is in direct conflict with long established antitrust precedent. On the basis of this statement alone, *certiorari* should be granted.

Whether the First Circuit's conclusions should be allowed to stand must be viewed in the broader context of the health care industry generally. Non-profit hospitals, such as the *amicus curiae* must be viewed apart from physicians. Nonprofit hospitals by their very nature do not seek to maximize their profits. These hospitals can therefore be expected to react in a wholly different manner than do profit maximizing actors, like the physicians in *Kartell,* when they are coerced into giving an "unreasonably low price". Nonprofit hospitals may engage in cost-shifting. These institutions price their services so they will break even in the long run, and thus any reduction in rates attributable to one group of purchasers will be compensated for by raising the cost of services provided to other purchasers.

[10] A significant ambiguity exists with regard to this limited exception the First Circuit was willing to make. It is unclear whether the predatory price referred to relates to the insurance product sold or the amount the physician is to be reimbursed.

Physicians on the other hand, having already priced their services at the profit maximizing level, will not further raise their rates to other purchasers if they give Blue Shield a discount.

The competitive significance of the existence of cost shifting on the health care marketplace is profound. Even if it is legitimate, as the Court of Appeals maintains, to exercise market power to get an "unreasonably" low price, it is certainly not competition on the merits to cause the costs of servicing that discount to be shifted to competitors. This leveraging of market power to increase a competitor's costs is just a variation on the price squeeze theme first articulated by Judge Learned Hand in *United States v. Aluminum Company of America,* 148 F.2d 416 (2d Cir. 1945). The Court of Appeals for the Seventh Circuit recently condemned a price squeeze in *City of Mishawaka v. American Electric Power Co.,* 616 F.2d 976 (7th Cir. 1980), *cert. denied,* 449 U.S. 1096 (1981). The impact of this cost shifting is to foreclose entry, and maintain the market shares of the dominant insurers. In the hospital services market the effect of cost shifting is particularly complicated given that hospitals are now starting to compete with traditional providers of prepaid health care financing by offering their own alternative delivery systems.

The First Circuit's assertions, divorced as they are from competitive realities in the health care marketplace, may chill competition in this industry. This Court should grant *certiorari* to address the First Circuit's unwarranted and broad based treatment of this issue, for significantly restraining competition in an industry, unlike the so-called benefit of monopoly pricing's attracting higher quality raw materials, is not "good", nor should it even be tolerated.

B. The First Circuit's Articulation of Acceptable Monopolistic Conduct Runs Contrary to Supreme Court Precedent.

The offense of monopolization was defined by Justice Douglas in *United States v. Grinnell Corp.,* 384 U.S. 563 (1966):

> The offense of monopoly under § 2 of the Sherman Act has two elements: (1) the possession of monop-

> oly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen or historic accident.

Id. at 570-71.

While the Court of Appeals referred to the "superior product" language above, it failed to explain how the willful extraction of an unreasonably low price which has the tendency to maintain or extend market power can be considered acceptable monopolistic conduct. Furthermore, the First Circuit's formulation of the law conflicts with the Second Circuit's decision in *United States v. Aluminum Company of America, supra,* wherein Judge Hand stated:

> It was not inevitable that [Alcoa] should always anticipate increases in the demand for ingot and be prepared to supply them. Nothing compelled it to keep doubling and redoubling its capacity before others entered the field. . . [We] can think of no more effective exclusion than progressively to embrace every new opportunity as it opened. . .
>
> * * *
>
> [N]o monopolist monopolizes unconscious of what he is doing.

Id. at 431-32.[11]

If *certiorari* is not granted, then the Court of Appeals would have effectively undermined *Alcoa* and *Grinnell.* The Court of Appeals, contrary to these cases has sanctioned monopolistic conduct designed to maintain Blue Shield's market share, conduct which the District Court determined was not supported by any procompetitive justification.

A further reason for granting *certiorari* is to give clear guidance as to the permissible scope of the exercise of monopsony power. Guidance is necessary given that the Court of

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[11] *Alcoa* was cited with approval in *Grinnel. See Grinnell,* 384 U.S. at 571.

Appeals would seemingly allow a purchaser to exercise whatever power it desired as the product of a rational firm's desire to "get the best deal possible". (*See* A16) This practically limitless buyer power is irreconcilable with this Court's decision in *Mandeville Island Farms v. American Crystal Sugar Co.*, 334 U.S. 219 (1948).

In *Mandeville,* three California sugar refiners occupying a monopolistic position in North California agreed to pay uniform prices for sugarbeets. The practice condemned by the Court was not merely the price-fixing by the dominant buyers, but the extraction of unreasonable terms and conditions made possible by the abuse of the refiners' monopoly power. In commenting on the controls imposed on the sugarbeet sellers by the refiners, this Court stated:

> Some of these controls have been built up by taking advantage of the opportunities afforded by the industry's unique character, both natural and in its general pattern and habits of organization; others by utilizing the key positions these advantages give the refiners to put contractual restraints upon the growers by their separate actions; and still greater ones by the refiners' ability by virtue of their central and dominating place thus achieved, to agree among themselves upon further restrictions.
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> * * *
>
> The farmers' only alternative to dealing with one of the three refiners is to stop growing beets. They can neither plant nor sell except at the refiners' pleasure and on their terms. The refiners thus effectively control the quantity of beets grown, harvested and marketed, and consequently of sugar sold from the area in interstate commerce even when they compete with each other. They dominate the entire industry. And their dominant position, together with the obstacles created by the necessity for large capital investment and the time required to make it productive, makes outlet through new competition practically impossible . . . A tighter or more all-inclusive monopolistic position hardly can be conceived.

Id. at 239-240.

In *United States v. Griffith,* 334 U.S. 100 (1948), this Court made clear that individual as well as concerted action by a buyer with monopoly power would constitute a violation of the antitrust laws:

> The consequence of such a use of monopoly power is that films are licensed on a non-competitive basis in what would otherwise be competitive situations. That is the effect whether one exhibitor makes the bargain with the distributor or whether two or more exhibitors lump together their buying power, as appellees did here. It is in either case a misuse of monopoly power under the Sherman Act. *United Stated v. Griffith,* 334 U.S. at 108.

The Court went on to state that if "monopoly power can be used to begat monopoly, the Act becomes a feeble instrument indeed. Large-scale buying . . . [may not be] used to stifle competition by denying competitors less favorably situated access to the market." *Id.*

Blue Shield's abuse of its monopoly power to coerce the physicians into providing their services at prices determined by Blue Shield's fee schedule which does not reflect the cost of such services is no different from the conduct condemned in *Mandeville Farms* and *Griffith.*

By granting *certiorari* this Court can therefore clarify that *Mandeville Farms* continues to be the governing authority. Clear direction will further indicate that the First Circuit's articulation of a judicial hesitancy to interfere "with a firm's freedom to set even anticompetitve prices" is misplaced. As *Berkey Photo, Inc. v. Eastman Kodak Co.,* 603 F.2d 263, 297 (2d Cir. 1979), *cert. denied,* 444 U.S. 1093 (1980), relied upon by the Court of Appeals, makes clear, judicial hesitancy to interfere with monopoly pricing arises from a desire to award damages only where unlawful conduct proximately caused the

injury.[12] The courts do not wish to punish a monopolist for lawful conduct. Thus when read in context, *Berkey Photo* cannot support the untenable position that a firm is free to extract unreasonably low prices without limit. As a consequence the First Circuit's so-called judicial hesitancy crumbles without the aid of a single authority on point.[13]

While any "rational enterprise" tries to "get the best deal possible", (*See* A16) the caselaw imposes restraints upon monopolists which other rational enterprises are not subject to because of their lack of market power. *MCI Communications v. American Telephone and Telegraph Co.*, 708 F.2d 1081, 1149 (7th Cir.), *cert. denied*, 104 S.Ct. 234 (1983). This rule of law bespeaks of infinite wisdom because the consequences attending the actions of a monopolist are felt in geometric proportions relative to the conduct of the ordinary business enterprise. As the Court of Appeals recognized, Blue Shield is able to extract a lower price as a product of its market share, which other actors in the market are not able to obtain. It is only fair that judicial scrutiny increase commensurately with the potential impact one's actions can have on the marketplace. Action, though lawful, which extends or enhances market power violates Section Two. To hold otherwise is to invite concentrations of economic power that undermine the very entrepreneurial spirit

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[12] Judge Kaufman's statement quoted by the First Circuit can more fully be appreciated in context:

> It is true . . . that excessive prices are "injury of the type the antitrust laws were intended to prevent. . . It is equally evident, however, that more than monopoly power is necessary to make the charging of a noncompetitive price unlawful. Accordingly, a purchaser may recover only for the price increment that "flows from" the distortion of the market caused by the monopolist's anticompetitive conduct.

Id. at 297.

[13] *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397-98 (1927), relied upon by the Court of Appeals, is also inapposite. It has long been recognized that the Court there rejected any inquiry into the reasonablness of the prices being fixed as a defense to charges brought under Section One. It is therefore quite ironic that the First Circuit has cited this language to support closing off any inquiry in a sutuation questioning the lawfulness of prices being fixed.

that full competition inspires. To require more is to encourage the monopolist to eliminate competition before being found in violation of the Act.

CONCLUSION

It is respectfully submitted that this Court should grant the petition for a writ of certiorari to address the broad issues raised and incorrectly decided by the Court of Appeals, issues which have the potential for affecting the entire health care industry.

Respectfully submitted,

DOUGLAS B. MCFADDEN
(Counsel of Record)
JOHN A. BORSARI
DAVID M. HALBREICH
MICHAEL I. ENDLER
DUTTON AND OVERMAN
2000 M Street, N.W., Suite 260
Washington, D.C. 20036
(202) 293-3700

REX P. KILLIAN
HALL, RENDER, KILLIAN,
HEATH & LYMAN
3921 N. Meridian Street
Suite 200
Indianapolis, Indiana 46208

Attorneys for Ball Memorial Hospital, Inc., et al.

CERTIFICATE OF SERVICE

I, JOHN A. BORSARI, certify that I have this 25th day of March, 1985 caused to be served a copy of the foregoing "Motion for Leave to File and Brief of Ball Memorial Hospital, Inc., *et al. Amicus Curiae*" by depositing three (3) copies of the same in the United States Mail, first class postage prepaid, addressed to the following counsel of record:

James vanR. Sringer
Dickstein, Shapiro & Morin
2101 L Street, N.W.
Washington, D.C. 20037

Thayer Fremont-Smith
Choate, Hall & Stewart
60 State Street
Boston, Massachusetts, 02109

Daniel O. Mahoney
Palmer & Dodge
One Beacon Street
Boston, Massachusetts 02108

H. Reed Witherby
Assistant Attorney General
Government Bureau
Room 2019
1 Ashburton Place
Boston, Massachusetts 02108

John A. Borsari

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JAMES P. KARTELL, M.D., ET AL.,
PETITIONERS,
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BLUE SHIELD OF MASSACHUSETTS, INC.
RESPONDENT.

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GRANT V. RODKEY, M.D., ET AL.,
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BLUE SHIELD OF MASSACHUSETTS, INC.,
RESPONDENT.

Respondent's Brief in Opposition to Petitions for Certiorari.

DANIEL O. MAHONEY,
Counsel of Record,
PALMER & DODGE,
One Beacon Street,
Boston, Massachusetts 02108.
(617) 227-4400

REGINALD H. HOWE,
Suite 2200,
One Beacon Street,
Boston, Massachusetts 02108.
(617) 227-4400

Dated: March 25, 1985

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Questions Presented.

Both petitions for certiorari fundamentally ask this Court to consider doing what the court of appeals refused to do: "create new potentially far-reaching law" on whether and under what circumstances contracts which simply set the price of the transaction at hand may violate § 1 of the Sherman Act. *Kartell* v. *Blue Shield of Massachusetts, Inc.*, 749 F.2d 922, 928 (CA1 1984) ("*Kartell VI*") (PA14).[1]

Blue Shield of Massachusetts, Inc. (Blue Shield) was established under a special act for the purpose of "furnishing medical services at low cost to members of the public who become subscribers . . . ." Mass. St. 1941, c. 306, preamble. The contracts between Blue Shield and its participating physicians, and between Blue Shield and its subscribers, require Blue Shield participating physicians in most instances to accept Blue Shield payments as payment-in-full for covered services rendered to Blue Shield subscribers, and prohibit participating physicians from making additional charges to subscribers, a practice known as "balance billing."

This case presented three basic issues regarding the prohibition on balance billing: (1) whether it is a "contract . . . in restraint of trade" in violation of § 1 of the Sherman Act, 15 U.S.C. § 1; (2) whether it is immune from antitrust attack under the state action doctrine of *Parker* v. *Brown*, 317 U.S. 341 (1943), and its progeny; and (3) whether it is exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015.

In a unanimous opinion by Breyer, J., the Court of Appeals for the First Circuit, bypassing the immunity and exemption issues, proceeded directly to the antitrust merits. *Kartell VI*, 749 F.2d at 924 (PA5). It held that "Blue Shield in essence

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[1] See *infra*, p. 4, fn. 3, for explanation of citation forms used in this brief.

'buys' medical services for the account of [its subscribers]" (*id.* at 925 (PA7)), that "the lawfulness of the [ban on balance billing] stems from the fact that it is an essential part of the price bargain between buyer [Blue Shield] and seller [participating physician]" (*id.* at 928 (PA14)), and that whether the "price bargain is, in fact, reasonable is, legally speaking, beside the point, even in the case of a monopolist [assuming that the price is not predatory]." *Id.* Accordingly, relying on a long line of analogous cases and considerable scholarly authority (see *infra*, pp. 10-13), the court of appeals "appl[ied] mainstream antitrust doctrine" (*id.* at 930 (PA18)) and held that the ban on balance billing was not a "contract in restraint of trade" within the meaning of § 1 of the Sherman Act regardless of Blue Shield's alleged market power.

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Nos. 84-1353, 84-1354.

In the

Supreme Court of the United States.

OCTOBER TERM, 1984.

No. 84-1353.

JAMES P. KARTELL, M.D., ET AL.,
PETITIONERS,
v.
BLUE SHIELD OF MASSACHUSETTS, INC.
RESPONDENT.

No. 84-1354.

GRANT V. RODKEY, M.D., ET AL.,
PETITIONERS,
v.
BLUE SHIELD OF MASSACHUSETTS, INC.,
RESPONDENT.

Respondent's Brief in Opposition to Petitions for Certiorari.

Opinions Below.

Both petitions for certiorari fail to append all pertinent opinions below as required by Rule 21(k)(ii), particularly: *Kartell* v. *Blue Shield of Massachusetts, Inc.*, 384 Mass. 409, 425

N.E.2d 313 (1981) ("*Kartell II*") (answering certified questions of state law); and *Kartell* v. *Blue Shield of Massachusetts, Inc.*, 542 F.Supp. 782 (D. Mass. 1982) ("*Kartell III*") (granting in part defendants' motion for summary judgment). These opinions are set forth in the appendix to this brief.

Pertinent Statutes.

In addition to the statutes cited by petitioners, this case involves the state enabling legislation for Blue Shield, Mass. Gen. Laws, c. 176B, as amended, the pertinent parts of which are set forth in the appendix to this brief. Of particular importance in connection with the petitions for certiorari is the recent amendment to Mass. Gen. Laws, c. 176B, § 7 (Mass. St. 1984, c. 192, § 1, effective July 12, 1984), making the Blue Shield ban on balance billing an express state statutory prohibition. This amendment was passed in response to the decision of the district court in this case and prior to the decision of the court of appeals for which certiorari is sought. See *infra*, pp. 17-18. The amendment provides in relevant part:

> No participating physician or other participating provider of health services shall charge to or collect from a subscriber or covered dependent any amount in excess of the amount of compensation determined and allowed by [Blue Shield] pursuant to the applicable method of compensation approved by the commissioner [of insurance], except [in certain limited circumstances not here material].

Statement of the Case.

I. Proceedings Below.

This action was originally brought by four Massachusetts physicians, two of whom were Blue Shield participating physicians and two of whom were not, for injunctive relief from alleged violations of §§ 1 and 2 of the Sherman Act by Blue Shield and by Blue Cross of Massachusetts, Inc. ("Blue Cross").[2] Subsequently the Massachusetts Medical Society (the "Medical Society"), which has sponsored and financed this and related cases from the outset, and two additional Massachusetts physicians were allowed to intervene as parties plaintiff, and the Massachusetts Commissioner of Insurance (the "Commissioner") was allowed to intervene as a party defendant.

On the merits, plaintiffs and intervenor-plaintiffs (the petitioners before this Court) principally challenged two practices of Blue Shield and one of Blue Cross: (1) the refusal of Blue Shield to provide benefits for services rendered by non-participating physicians except in an emergency or outside Massachusetts; (2) the refusal of Blue Cross to provide benefits for physicians' services except those rendered by salaried staff of institutional providers such as hospitals; and (3) the requirement that Blue Shield participating physicians in most instances accept the Blue Shield payments as payment-in-full for services rendered to Blue Shield subscribers and not "balance bill" subscribers for additional amounts. Petitioners contended that the first two practices constituted a concerted refusal to deal and

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[2] A related case, *Grant V. Rodkey, et al.* v. *Blue Shield of Massachusetts, Inc., et al.*, United States District Court for the District of Massachusetts, No. 82-317-C, raising a claim for treble damages on account of the ban on balance billing and other alleged wrongs, remains pending.

an attempt to monopolize the market for prepaid health care by Blue Shield and Blue Cross, and that the third constituted illegal price-fixing by Blue Shield or was otherwise an unlawful contract in restraint of trade under § 1 of the Sherman Act.

Blue Shield and Blue Cross denied that these practices violated the federal antitrust laws, and further contended that all three were immune under the state action doctrine of *Parker* v. *Brown*, 317 U.S. 341, 350-352 (1943), and its progeny, and exempt under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015.

This case has produced six reported opinions, including three by the Court of Appeals for the First Circuit, two by the District Court for the District of Massachusetts, and one by the Supreme Judicial Court of Massachusetts answering relevant questions of state law certified by the district court. These opinions, all of which bear the caption *Kartell* v. *Blue Shield of Massachusetts, Inc.*, are in chronological order: *Kartell I*, 592 F.2d 1191 (CA1 1979) (vacating and remanding judgment of dismissal on state action grounds); *Kartell II*, 384 Mass. 409, 425 N.E.2d 313 (1981) (RA1a-19a) (answering certified questions); *Kartell III*, 542 F.Supp. 782 (D. Mass. 1982) (RA20a-35a) (partial summary judgment for defendants); *Kartell IV*, 687 F.2d 543 (CA1 1982) (dismissing appeal from order denying intervenor-plaintiffs permission to raise new claims); *Kartell V*, 582 F.Supp. 734 (D. Mass. 1984) (PA28-68) (judgment enjoining Blue Shield from enforcing the ban on balance billing); and *Kartell VI*, 749 F.2d 922 (CA1 1984) (PA1-25) (reversing judgment enjoining the ban on balance billing; affirming remainder of judgment in favor of defendants).[3] The procedural history of this case and related cases is

[3] Citations in this brief to *Kartell II* and *Kartell III* are to the official reports and the corresponding pages in the appendix to this brief, cited "RA" followed by the page number. Citations in this brief to *Kartell V* and *Kartell VI* are to the official reports and the corresponding pages in the appendix to the petition in No. 84-1353, cited "PA" followed by the page number. Citations to *Kartell I* and *Kartell IV* are to the official reports only, neither opinion having been included in the appendix to either petition.

set out in detail in *Kartell IV*, 687 F.2d at 545-548, and *Kartell V*, 582 F.Supp. at 735-737 (PA29-32).

Following the decision of the Supreme Judicial Court in *Kartell II*, the district court on cross-motions for summary judgment held that Blue Shield's refusal to provide benefits for non-emergency services rendered by non-participating physicians in Massachusetts, and Blue Cross's refusal to provide benefits for physicians' services generally, are immune from antitrust challenge under the state action doctrine. *Kartell III*, 542 F.Supp. at 788-792 (RA26a-30a). However, the district court held that the ban on balance billing was neither immune under the state action doctrine (*id.*) nor exempt under the McCarran-Ferguson Act. *Id.* at 792-794 (RA30a-32a). It further held that the ban on balance billing was not a *per se* violation of § 1 of the Sherman Act (*id.* at 794-796 (RA32a-34a), but that it should be tested under the rule of reason. *Id.* at 796 (RA34a). After trial without jury, the district court ruled that the ban on balance billing was an unreasonable restraint of trade under § 1 of the Sherman Act and enjoined its further use by Blue Shield. *Kartell V*, 582 F.Supp. at 755 (PA67). In all other respects the case was dismissed. *Id.* at 755 (PA67, 72).

On appeal, the court of appeals (Campbell, Breyer and Cowen, JJ.), in a unanimous opinion by Breyer, J., reversed the district court's ruling that the ban on balance billing was unlawful, vacated the injunction enjoining its further use, and affirmed the district court's judgment dismissing the case in all other respects. *Kartell VI*, 749 F.2d at 934 (PA25).[4]

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[4] The court of appeals did not reach the issues of state action immunity or McCarran-Ferguson Act exemption for the ban on balance billing. However, these issues were fully tried and briefed at every level below. Accordingly, should this Court decide to review the judgment of the court of appeals, the judgment could be sustained on either of these grounds even though that court did not reach them. *United States* v. *New York Telephone Co.*, 434 U.S. 159, 166, n. 8 (1977). *Dandridge* v. *Williams*, 397 U.S. 471, 475-476, n. 6 (1970).

II. Relevant Facts.

The history, development and current operation of the Blue Shield system are described generally in *Kartell II*, 384 Mass. at 414-418, 420-421, 423-425 (RA6a-10a, 12a-13a, 15a-17a). Blue Shield is the only medical service corporation organized under Mass. Gen. Laws c. 176B, and operates a non-profit medical service plan pursuant to that chapter. It is subject to comprehensive administrative regulation by the Commissioner, who must approve, *inter alia*, its subscriber contracts, subscriber rates, contracts with participating physicians and other providers and methods of compensating participating physicians and other providers. *Id.* at 422 (RA14a) (citing *Nelson* v. *Blue Shield of Massachusetts, Inc.*, 377 Mass. 746, 750, 387 N.E.2d 589, 592 (1979)).

Restrictions on balance billing have been an integral and important part of the Blue Shield system since its establishment in 1942. See *Kartell II*, 384 Mass. at 415-418 (RA7a-10a). Without such restrictions or their functional equivalent, Blue Shield would be unable to carry out its statutory purpose of "furnishing medical services at low cost to members of the public who become subscribers . . . ." Mass. St. 1941, c. 306, preamble. These restrictions enable Blue Shield to provide "service" benefits for covered medical services. In essence, service benefits are full benefits except for such limited deductibles or co-payments as may be specified in the subscriber contract.

To both carry out its statutory purpose and meet the demand of consumers and employers for full benefits for a broad range of medical services, Blue Shield contracts with physicians and other providers to pay them for covered services rendered to Blue Shield subscribers and covered dependents (collectively "members"). Under these contracts, participating providers agree to accept Blue Shield payments as payment-in-full and

not to try to collect additional payments directly from Blue Shield members.[5] This prohibition of additional charges is the "ban on balance billing" to which the petitioners object.

What the petitioners want is the right to collect an additional $100 million annually from Blue Shield members. They demand this right notwithstanding that imperfections in the physicians' services market already allow them monopolistic power over their fees (see *infra*, p. 11), notwithstanding increases in their fees and incomes far exceeding those of comparable occupational groups (see Exs. 2309-2310; Tr. 1035-1036), and notwithstanding a relative oversupply of physicians in Massachusetts. See *Kartell VI*, 749 F.2d at 927 (PA10-11). All that Blue Shield has done is to set its own buying prices for the services that it purchases on behalf of its members. It is conceded that Blue Shield has not entered into any form of horizontal agreement on price or otherwise. *Kartell VI*, 749 F.2d at 932 (PA21).

Since 1968, with the express approval of the Commissioner, Blue Shield payments to physicians have generally been determined by a formula or methodology known as the "usual and customary charge" system. *Kartell V*, 582 F.Supp. 740-741 (PA37-39). Briefly stated, paying usual and customary charges means paying a participating physician his or her usual charge for a service, except as that charge exceeds the customary charge for the service by physicians of similar training and experience in the same area.[6] The method was adapted from

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[5] Similarly, health maintenance organizations, independent practice associations and preferred provider organizations enter into agreements with physicians requiring them to accept payments from the plan as payment-in-full and to refrain from billing covered individuals for any difference between the physician's charge and the plan's allowance or payment. *Kartell VI*, 749 F.2d at 928-929 (PA14).

[6] The allowable charge for a service is the lesser of the physician's submitted charge, his or her usual charge for the service (the "level 1" charge) or the

and is similar to the prevailing charge method used under Medicare — Part B, which had been introduced in 1966. 42 U.S.C. § 1395j *et seq.*

In 1977, the Commissioner approved modifications to the usual and customary charge system which allowed Blue Shield to set maximum allowable percentage increases for both usual and customary charges, and limited the allowable percentage increase for customary charges to a percentage no greater than the percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers, Boston, All Items, less the medical care component thereof.

As to participating physicians and other participating providers, the ban on balance billing has been regularly and consistently enforced by a special administrative board established under Mass. Gen. Laws c. 176B, § 12, consisting of the Commissioner, the Attorney General and the Chairman of the Board of Registration in Medicine, or their designees (Exs. 815-854). It has also been enforced by the Attorney General under Mass. Gen. Laws c. 93A, which prohibits unfair and deceptive trade practices (Ex. 1167). In 1976 and 1977, the Commissioner twice refused to approve any relaxation of the ban on balance billing (Exs. 638-639, 648-649). In 1984, less than four months after the district court decision purporting to invalidate it, the ban on balance billing was made an express state statutory prohibition by act of the Massachusetts Legislature. See *infra*, pp. 17-18.

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applicable customary charge (the "level 2" charge). A physician's usual or level 1 charge was originally defined as the median of his or her reported charges submitted to Blue Shield during the applicable charge-reporting period. The customary or level 2 charge was originally defined as the 90th percentile of the usual charges for the service by established physicians within the same specialty and geographic area during the applicable charge-reporting period. Today, both usual and customary charges are subject to further limitations as described below.

Notwithstanding that over one-half of all Massachusetts residents are Blue Shield members, Blue Shield payments subject to the ban on balance billing account for only about 14 percent of total physicians' revenues in Massachusetts. *Kartell VI*, 749 F.2d at 924 (PA4). For services subject to the ban, the aggregate difference between submitted charges by participating physicians and Blue Shield payments to them was $69 million in 1979, $73 million in 1980, $81 million in 1981, $94 million in 1982, and was projected to be $103 million in 1983. *Kartell V*, 582 F.Supp. at 741 (PA39). Expressed as a percentage of submitted charges, these differences rose from 18.4 percent in 1976 to 30.7 percent in 1981, and have remained near the 30 percent figure since 1981. *Id.* If the ban on balance billing were eliminated, Blue Shield's subscribers would become liable for these amounts, either directly through additional charges by participating physicians or indirectly through the higher subscriber rates which Blue Shield would have to charge in order to pay full submitted charges to participating physicians.

Summary of Argument.

Certiorari should not be granted for two basic reasons: (1) the decision of the court of appeals in this case represents a well-reasoned application of "mainstream antitrust doctrine" fully supported by prior decisions of this Court, the decisions of four other courts of appeals and several district courts in similar cases, and the weight of scholarly authority (pp. 10-17); and (2) the ban on balance billing, having been enacted as a state statutory prohibition following the decision of the district court in this case, is now immune from antitrust scrutiny, thus depriving this case of any significance for the future (pp. 17-18).

Argument.

I. The Decision of the Court of Appeals Is in Accordance with Similar Decisions of This Court, Four Other Courts of Appeals, and the Weight of Scholarly Comment.

Section 1 of the Sherman Act states that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C. § 1. Simple contracts for the purchase and sale of goods or services, however, have never been considered "contract[s] . . . in restraint of trade" within the meaning of § 1 because they do no more than set the price and other terms of the transaction at hand. As the Seventh Circuit stated in *Quality Auto Body* v. *Allstate Insurance Co.*, 660 F.2d 1195, 1203 (CA7 1981), *cert. denied*, 455 U.S. 1020, 1023 (1982):

> A contract of this nature between a buyer (the insurance company) and a seller (the body shop) generally does not, without more, appear to violate the antitrust laws at all. Only if such an agreement contains restrictions on the party's activities *other than those involved in the immediate purchase and sale does* the possibility of a Sherman Act violation arise. [Emphasis by the court.]

Accord, *Proctor* v. *State Farm Mutual Insurance Co.*, 675 F.2d 308 (CADC 1982) *cert. denied*, 459 U.S. 839 (1982). See *Sitkin Smelting and Refining Co.* v. *FMC Corp.*, 575 F.2d 440, 446 (CA3 1978), *cert. denied*, 439 U.S. 866 (1978); *Mulhearn* v. *Rose-Neath Funeral Home, Inc.*, 512 F.Supp. 747, 753-754 (W.D. La. 1981) (funeral service insurance pol-

icy setting the amount to be paid for the service is not an antitrust violation because "to agree upon a price with a customer in the absence of other circumstance is not within the legal prohibition").

In *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 214 (1979), this Court described contracts providing for direct payments by Blue Shield of Texas to participating pharmacies for drugs provided to subscribers as "arrangements for the purchase of goods and services by Blue Shield." Because of the purchaser-seller relationship between Blue Shield plans and their participating providers, the courts of appeals in four circuits in addition to the First Circuit have held that a ban on balance billing does not violate the antitrust laws. *Pennsylvania Dental Association* v. *Medical Service Association of Pennsylvania*, 745 F.2d 248, 256-257, 259 (CA3 1984), *pet. for cert. filed*, 53 U.S.L.W. 3619 (No. 84-1296, February 13, 1985). *Royal Drug Co.* v. *Group Life & Health Insurance Co.*, 737 F.2d 1433, 1437-1438 (CA5 1984), *cert. denied*, 105 S.Ct. 912 (1985). *Sausalito Pharmacy, Inc.* v. *Blue Shield of California*, 677 F.2d 47 (CA9 1982) (*per curiam*) (affirming 544 F.Supp. 230 (N.D. Cal. 1981)), *cert. denied*, 459 U.S. 1016 (1982).[7] *Medical Arts Pharmacy of Stamford, Inc.* v. *Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502 (CA2 1982) (*per curiam*) (affirming 518

[7] In *Sausalito*, the plaintiff pharmacies alleged that § 1 of the Sherman Act was violated by provisions in Blue Shield's contracts prohibiting participating pharmacies from charging Blue Shield subscribers more than a specified amount — the so-called "deductible" — for covered drugs. The district court concluded that "contracts between purchasers and sellers do not impermissibly restrain trade unless there is some effect on price formation other than the terms of the contract itself." *Sausalito*, *supra*, 544 F.Supp. at 237 (citing *Blue Cross & Blue Shield* v. *Michigan Association of Psychotherapy Clinics*, *infra*). Because there was no such effect on price formation, the court granted Blue Shield's motion for summary judgment. The Ninth Circuit affirmed on the basis of the district court's opinion. *Sausalito*, *supra*, 577 F.2d at 48.

F.Supp. 1100 (D. Conn. 1981)).[8] Several district courts have held similarly on motions to dismiss or for summary judgment. *Davidowitz* v. *San Diego County Dental Society*, 1983-1 Trade Cases (CCH) ¶ 65,231 (S.D. Cal. 1983). *Michigan State Podiatry Association* v. *Blue Cross and Blue Shield of Michigan*, 1982-2 Trade Cases (CCH) ¶ 64,801 (E.D. Mich. 1982). *Feldman* v. *Health Care Service Corp.*, 562 F.Supp. 941 (N.D. Ill. 1982). *Blue Cross & Blue Shield of Michigan* v. *Michigan Association of Psychotherapy Clinics*, 1980-2 Trade Cases (CCH) ¶ 63,351 (E.D. Mich. 1980).

There are no cases to the contrary. Indeed, as one court noted:

> [E]ach federal court which has examined the question in the context of the antitrust laws has decided that an insurer paying out pursuant to its policy of insurance is actually a purchaser of goods or services, and that the insured is merely the recipient of the goods or services pursuant to the policy.

Feldman v. *Health Care Service Corp. supra*, 562 F.Supp. at 947 (citing *Sausalito, supra, Medical Arts, supra, Quality Auto Body, supra, Proctor, supra*, and *Michigan Association of Psychotherapy Clinics, supra*). Furthermore, as the court of appeals in this case observed, "scholarly commentators believe that these cases were correctly decided." *Kartell VI*, 749

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[8] In *Medical Arts*, Blue Cross Blue Shield provided for a "maximum billable amount" method of reimbursement under which it determined the maximum amount it would pay participating pharmacies for any drug. The court considered whether the provider agreement affected the prices for prescription drugs sold to non-Blue Cross Blue Shield customers, prices for non-drug items, or prices charged by non-participating pharmacies. Since there were no effects on parties or items apart from the contract terms themselves, the Second Circuit upheld summary judgment for Blue Cross Blue Shield. *Medical Arts, supra*, 675 F.2d at 506-507.

F.2d at 926 (PA9) (citing P. Areeda, *Antitrust Analysis*, pp. 530-531 (1981) ("[I]t is difficult to see what could make [such an] arrangement anticompetitive.")). Accordingly, there is no basis for granting certiorari. See Rule 17.1. Far from being in conflict, the courts of appeals in five circuits, taking their lead from this Court's decision in *Group Life & Health Insurance Co.* v. *Royal Drug*, *supra*, 440 U.S. at 214, are in agreement that a Blue Shield plan should, for purposes of applying the antitrust laws, be characterized or treated as a purchaser *vis-a-vis* its participating providers.

Strictly speaking, as the petitioners correctly point out, the courts in both *Sausalito* and *Medical Arts* held that the provider agreements at issue did not violate § 1 of the Sherman Act because they were not unreasonable restraints of trade, not because they were not restraints of trade at all. In this connection, the courts recognized that the agreements were not horizontal price-fixing, resale price maintenance or any other traditional type of *per se* violation. *Sausalito*, *supra*, 544 F.Supp. at 234. *Medical Arts*, *supra*, 675 F.2d at 505-506, and 518 F.Supp. at 1106-1107. Nevertheless, they then went on to analyze whether the agreements were unreasonable vertical restraints of trade notwithstanding that they merely set the price for the transactions at issue. In the present case, the court of appeals recognized that this sort of additional analysis was unnecessary because § 1 of the Sherman Act is not concerned with the reasonableness of a price agreed to by a purchaser and a seller unless that price is predatory or below incremental cost. *Kartell VI*, 749 F.2d at 927-928 (PA12-13). Otherwise, every purchase and sale contract could be challenged as an unreasonable restraint of trade, and the courts could become involved in determining the reasonableness of the agreed price for almost any transaction affecting interstate commerce. See *United States* v. *Trenton Potteries Co.*, 273 U.S. 392, 398 (1927) ("[W]e should hesitate to adopt a construction making

the difference between legal and illegal conduct in the field of business relations depend upon so uncertain a test as whether prices are reasonable . . .").

In an effort to distinguish this case, petitioners emphasize Blue Shield's alleged market power as a buyer in the physicians' services market. But, as the court of appeals pointed out, absent predatory or below cost pricing, "even a monopolist is free to exploit whatever market power it may possess when that exploitation takes the form of charging uncompetitive prices." *Kartell VI*, 749 F.2d at 927 (PA12), and cases and authorities cited. Since there was no evidence of predatory pricing by Blue Shield (*id.* at 928 (PA13)), the court of appeals held that the ban on balance billing was lawful even assuming, which it did not decide, "that Blue Shield possesses significant market power . . . . [and] uses that power to obtain 'lower than competitive' prices." *Id.* at 927 (PA12).[9]

The petitioner's reliance on *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332 (1982), is misplaced. In *Maricopa*, the Court invalidated a horizontal agreement among competing physicians on their maximum charges to a prepaid

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[9] The court of appeals expressly recognized that "Blue Shield disputes the existence of significant 'market power" (*id.* at 926 (PA10)), noting that 99 per cent of Massachusetts physicians might participate whether Blue Shield had ten thousand or several million subscribers, that the supply of physicians in Massachusetts had "'increased steadily during the past decade,'" and that the issue of market power was "hotly debated by the expert economists who testified at trial." *Id.* at 926-927 (PA10-11).

In this connection, the district court's finding that Massachusetts physicians are required to participate with Blue Shield as "a matter of economic necessity" (*Kartell V*, 582 F.Supp. at 748 (PA54)) confuses the effects of the ban on balance billing with the effects of Blue Shield's refusal to provide benefits for non-emergency services rendered in Massachusetts by non-participating physicians, which is immune from antitrust scrutiny under the state action doctrine. *Kartell III*, 542 F.Supp. at 788-792 (RA26a-30a). Any loss of revenue to the petitioners that results from non-participation is an economic consequence of this refusal, not the ban on balance billing.

health care plan organized and controlled by them. Recognizing the difference between the horizontal restraint at issue in *Maricopa* and the vertical relationship here, the court of appeals correctly held that "*Maricopa* is simply not on point." *Kartell VI*, 748 F.2d at 930 (PA18).

In fact, *Maricopa* strongly indicates that a ban on balance billing implemented by an insurer is lawful and pro-competitive.[10] The Court noted (457 U.S. at 352):

> It is true that a binding assurance of complete insurance coverage — as well as most of the respondents' potential for lower insurance premiums — can be obtained only if the insurer and the doctor agree in advance on the maximum fee that the doctor will accept as full payment for a particular service. [Footnote omitted.]

The Court then stressed that insurers could achieve the same result without horizontal agreements among providers (*id.* at 353):

> *[I]nsurers are capable not only of fixing maximum reimbursable prices but also of obtaining binding agreements with providers guaranteeing the insured full reimbursement of a participating provider's fee.* In light of these examples, it is not surprising that nothing in the record even arguably supports the conclusion that this type of insurance program could not function if the fee schedules were set in a different way [than by horizontal agreement among providers]. [Emphasis supplied.]

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[10] The Solicitor General's *amicus curiae* brief in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1970), made the same point: provider agreements are legal, absent evidence of a horizontal conspiracy. See *Maricopa*, *supra*, 457 U.S. at 353, n. 26.

The Court's recent decision in *Jefferson Parish Hospital District No. 2* v. *Hyde*, 466 U.S. , 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984), confirms that the antitrust laws do not condemn agreements between insurers and providers setting the price of services rendered to insureds. In *Hyde*, the Court held that the *per se* rule against tying arrangements did not apply to an exclusive contract between a hospital and a group of anesthesiologists. The Court noted that the "prevalence of third-party payment for health care costs reduces price competition, and a lack of adequate information renders consumers unable to evaluate the quality of the medical care provided by competing hospitals." *Id.*, 80 L.Ed.2d at 22.[11] In this setting, the Court observed: "Insurance companies are the principal source of price restraint in the hospital industry; they place some limitations on the ability of hospitals to exploit their market power." *Id.*, 80 L.Ed.2d at 23, n. 47.

Finally, the petitioners erroneously suggest that the court of appeals decided "'to tolerate manifestly anticompetitive conduct'" in violation of accepted antitrust principles because of the lower prices and savings to consumers generated by the Blue Shield system. Petition in No. 1353, p. 16. In fact, the

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[11] In the present case, the economic experts agreed with this point. The petitioners' own expert testified (Tr. 744-745, 763-768, 771):

> We take the view that medical care is provided monopolistically. The monopoly does not arise from the usual [cause] of a small number of sellers; even reasonably small cities usually contain several hospitals and scores of physicians. The monopoly problem arises because of the extremely poor and costly information available to medical consumers. Since consumers are not well aware of price, attractiveness and quality for the many alternative sources of medical care, each provider has something of a 'captive market.' If he were to raise his price somewhat, some but not all of his customers would desert him. On the other hand, if he were to lower his price, he would gain some customers but not the large number required to induce competitive behavior.

court of appeals noted "three considerations [which] convince us to apply mainstream antitrust doctrine" and which "militate strongly here against any effort by an antitrust court to supervise the Blue Shield/physician price bargain." *Kartell VI*, 749 F.2d at 930 (PA18). These considerations were: (1) that the prices at issue were low prices rather than high ones; (2) that the area of medical costs is one of "great complexity where more than solely economic values are at stake" (*id.* at 931 (PA19)); and (3) that the Blue Shield system, including payments to participating physicians, is "supervised by state regulators." *Id.* However, the court of appeals emphasized (*id.*): "These general considerations do not dictate our result . . . . They do, however, counsel us *against departing from present law* or extending it to authorize increased judicial supervision of the buyer/seller price bargain." [Emphasis supplied.] Even the petitioners concede that "this Court has not specifically applied the rule of reason to the price terms of a purchase contract . . . ." Petition in No. 1353, p. 11. It is they, not the court of appeals, who would depart from present law and "'blaze new trails.'" *Kartell VI*, 749 F.2d at 931 (PA19) (quoting *Feldman* v. *Health Care Service Corp.*, *supra*, 562 F.Supp. at 946).

II. Since the Ban on Balance Billing Is Now a State Statutory Prohibition, Further Review by This Court Is Unwarranted.

Within four months after the decision of the district court holding that the ban on balance billing violated § 1 of the Sherman Act, the Massachusetts Legislature enacted by unanimous vote a new statute making the ban a state statutory prohibition. Mass. St. 1984, c. 192, § 1 (see *supra*, p. 2). Passed with an emergency preamble, the new statute became

effective on the date of enactment, July 12, 1984. Whatever the status of ban on balance billing under the state action doctrine prior to that date (see *supra*, p. 5, n. 4), after that date it became immune from antitrust scrutiny under *Hoover* v. *Ronwin*, 467 U.S. , , 104 S.Ct. 1989, , 80 L.Ed.2d 590, 599 (1984) (conduct of state legislature *ipso facto* immune from antitrust challenge). Accordingly, the injunction granted by the district court could not be reinstated even if the court of appeals were wrong on the antitrust merits, which it was not.[12]

This Court should not grant certiorari to review a question which has been essentially resolved by a subsequent statute (*Cook* v. *Hudson*, 429 U.S. 165, 165-166 (1976)), or which, to the extent that it has significance for the future, arises under a new statute. *Triangle Improvement Council* v. *Ritchie*, 402 U.S. 497, 498-501 (1971) (opinion of Mr. Justice Harlan).

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[12] The court of appeals acknowledged "the claim that a recently enacted state law, Mass. St. 1984, ch. 192, § 1, renders the case moot by immunizing Blue Shield's 'balance billing ban' from the reach of the antitrust laws." *Kartell VI*, 749 F.2d at 924 (PA5). However, recognizing, *inter alia*, that "the new statute may not immunize the defendants from treble-damage liability for past conduct," the court of appeals considered it "simpler and more appropriate to proceed directly to the antitrust merits." *Id.* The reference to "treble-damage liability" was a reference to the pending action for damages by substantially the same plaintiffs in the district court. See *supra*, p. 3, n. 2. The court of appeals apparently thought that if it did not decide the antitrust merits in this case, involving only an injunction as to future use of the ban, it might well have to decide them later in the related case involving damages for use of the ban prior to the adoption of the new statute. In practical terms, therefore, all that is at issue if this Court grants certiorari is the extent of the preclusive effect of the court of appeals judgment in this case on the pending damage action.

Conclusion.

For the foregoing reasons, the petitions for certiorari should be denied.

Respectfully submitted,

DANIEL O. MAHONEY,
Counsel of Record,
PALMER & DODGE,
One Beacon Street,
Boston, Massachusetts 02108.
(617) 227-4400

REGINALD H. HOWE,
Suite 2200,
One Beacon Street,
Boston, Massachusetts 02108.
(617) 227-4400

Dated: March 25, 1985

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JAMES P. KARTELL & others[1] *vs.* BLUE SHIELD OF MASSACHUSETTS, INC. & others.[2]

Suffolk. May 7, 1981. — August 20, 1981.

Present: HENNESSEY, C.J., LIACOS, ABRAMS, & NOLAN, JJ.

Medical Service Corporation. Administrative Law, Primary jurisdiction. *Insurance*, Commissioner of Insurance.

In considering questions certified by a judge of the United States District Court for the District of Massachusetts in an action by certain physicians against Blue Shield of Massachusetts, Inc., and Blue Cross of Massachusetts, Inc., this court declined to invoke the doctrine of primary jurisdiction to refer the questions to the Commissioner of Insurance for his determination where the certified questions involved matters of law and the application of principles of statutory construction and presented no unresolved factual issues. [412-414]

There is nothing in the broadly stated purpose of G. L. c. 176B or in the comprehensive regulatory power of the Commissioner of Insurance under c. 176B from which may be inferred a State policy requiring, or authorizing the Commissioner to require, that physicians who have signed agreements for services to subscribers of Blue Shield of Massachusetts, Inc., accept the fee paid by Blue Shield as payment in full for covered services. [414-423]

General Laws c. 176B, § 7, precludes payments by Blue Shield of Massachusetts, Inc., to physicians who have not signed Participating Agreements with Blue Shield for services rendered to subscribers except in cases of emergency or when services are rendered outside the State. [423-425]

Blue Cross of Massachusetts, Inc., is not empowered under G. L. c. 176A to make payments to subscribers or physicians for physicians' services [426-427], although it is permitted by c. 32A, § 4, to contract with the Group Insurance Commission to make payments for such services rendered to State employees [427].

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[1] Kartell is joined by three other Massachusetts physicians as parties plaintiff.

[2] The second named defendant is Blue Cross of Massachusetts, Inc. The Commissioner of Insurance has intervened as a party defendant.

QUESTIONS OF LAW certified to the Supreme Judicial Court by the United States District Court for the District of Massachusetts.

James van R. Springer of the District of Columbia (*Stanley V. Ragalevsky* with him) for the plaintiffs.

Daniel O. Mahoney (*Reginald H. Howe* with him) for Blue Shield of Massachusetts & another.

Paul W. Johnson, Assistant Attorney General, for Commissioner of Insurance, intervener.

NOLAN, J. On January 16, 1981, a judge of the United States District Court for the District of Massachusetts certified to this court two questions relating to a private antitrust action now pending in the Federal court. The questions are as follows:

"1. Is Blue Shield of Massachusetts, Inc. compelled by M.G.L. c. 176B, § 7 or any other Massachusetts statute or required by any clearly articulated and affirmatively expressed State policy (a) to limit fees of participating physicians as described in the annexed Stipulation and (b) to refuse to make payment for non-emergency services provided in Massachusetts by physicians who decline to accept the terms imposed by Blue Shield in their participation agreement, including such limitation of fees?

"2. Is Blue Cross of Massachusetts, Inc. permitted generally under the Massachusetts statutes to make payments to subscribers or physicians for medical services provided by physicians to Blue Cross-Blue Shield subscribers, as it does under its contract insuring employees of the Commonwealth?" For the reasons which follow, we answer question 1(a) and 2 in the negative. We answer question 1(b) in the affirmative.

I. *Background.*

The plaintiffs, four Massachusetts physicians, seek injunctive relief under § 16 of the Clayton Act, 15 U.S.C. § 26 (1976), against certain practices of the defendants, Blue Shield of Massachusetts, Inc. (Blue Shield), and Blue Cross of Massachusetts, Inc. (Blue Cross), which are alleged to operate in restraint of trade in violation of §§ 1 and 2 of

the Sherman Act, 15 U.S.C. §§ 1 and 2 (1976). Specifically, the plaintiffs allege that a) by refusing to reimburse physicians who have not signed Participating Physician's Agreements with Blue Shield for services to subscribers, except in emergencies or for services rendered outside Massachusetts, and b) by requiring that participating physicians accept Blue Shield's reimbursement as payment in full in most cases, Blue Shield is engaged in unlawful price setting. The plaintiffs further allege that Blue Cross has conspired with Blue Shield in refusing to provide benefits for physicians' services other than those rendered by the salaried staff of institutional providers such as hospitals and those rendered under Blue Cross's contract covering State employees, thereby perpetuating Blue Shield's alleged dominance in the market for physicians' services.

The defendants raised the defense that the challenged practices are immune from Federal antitrust attack under the "state action" exemption recognized in *Parker* v. *Brown*, 317 U.S. 341 (1943), and most recently articulated in *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). This contention was supported by the Commissioner of Insurance (Commissioner) and initially accepted by the trial judge, who in August, 1978, ordered the complaint dismissed. On appeal, however, the United States Court of Appeals for the First Circuit reversed, holding that the questions of statutory construction raised by the State action defense should initially be determined by the State courts. *Kartell* v. *Blue Shield of Mass., Inc.*, 592 F.2d 1191 (1st Cir. 1979). The Court of Appeals accordingly directed the District Court to abstain pending our decision in *Nelson* v. *Blue Shield of Mass., Inc.*, 377 Mass. 746 (1979), and, if sufficient guidance was not provided by that decision, to consider certifying questions to this court. *Kartell* v. *Blue Shield of Mass., Inc.*, *supra* at 1195. After determining that the *Nelson* decision did not speak to the central statutory issues raised by the instant case, the trial judge proceeded with this certification. The materials before us include the briefs

of the parties, including the Commissioner, a stipulation of facts accompanied by a documentary appendix, and certain materials developed during the discovery phase of the Federal litigation.

II. *Primary Jurisdiction.*

As a threshold matter, the defendants invoke the doctrine of primary jurisdiction, and urge that we refer both certified questions to the Commissioner of Insurance for his formal consideration. We decline to do so.

The doctrine of primary jurisdiction permits a court to refrain from exercising its jurisdiction until an administrative agency has determined some question or some aspect of a question arising in the proceeding before that court. 3 K.C. Davis, Administrative Law § 19.01, at 3 (1958). See *Murphy* v. *Administrator of the Div. of Personnel Administration*, 377 Mass. 217, 220-222 (1979). A court will apply the doctrine to promote uniformity of regulation and to take advantage of an agency's special expertise. *Mashpee Tribe* v. *New Seabury Corp.*, 592 F.2d 575, 580 (1st Cir. 1979). See *Nader* v. *Allegheny Airlines, Inc.*, 426 U.S. 290, 303-304 (1976). In antitrust cases, the doctrine of primary jurisdiction may provide a means of accommodating Federal antitrust policy to an agency's regulatory policy. 3 K.C. Davis, Administrative Law § 19.05, at 26 (1958). See *Ricci* v. *Chicago Mercantile Exchange*, 409 U.S. 289 (1973); Jaffe, Primary Jurisdiction, 77 Harv. L. Rev. 1037, 1069-1070 (1964). Its use in a given case, however, rests in the sound discretion of the trial judge. *Lehman Bros.* v. *Schein*, 416 U.S. 386, 391 (1974).

In the instant case, the judge who certified questions of law to this court has already considered the applicability of the doctrine of primary jurisdiction. He rejected the defendants' comparison of the allegations in this case with those in *Nelson* v. *Blue Shield of Mass., Inc., supra*, where we applied the doctrine to dismiss a complaint alleging that certain of Blue Shield's practices, regulated by the Commissioner, violated State law provisions which are enforced in the first instance by the Commissioner. The judge con-

cluded that in the instant case "[t]he threshold question . . . is purely one of state statutory construction; no fact-finding, administrative proceedings are necessary or even relevant." Because we agree with the statement, we need not reach the question whether, under our Uniform Certification of Questions of Law rule, S.J.C. Rule 1:03, as appearing in 382 Mass. 700 (1981), we possess the power to refer certified questions to an agency for its consideration, especially when the Federal trial court has already refused to do so. See *SDK Medical Computer Servs. Corp.* v. *Professional Operating Management Group, Inc.*, 371 Mass. 117, 126-127 (1976), which held that, although it is possible that certain charges as to unfair competitive practices by Blue Shield should be initially referred to the Commissioner of Insurance for correction under his administrative authority, the matter is one for consideration by the trial court. But see *Kartell* v. *Blue Shield of Mass., Inc.*, 592 F.2d 1191, 1196 (1st Cir. 1979) (Coffin, C.J., dubitante) ("[I]f, in the process of considering the questions certified the Massachusetts court finds the record to be inadequate, I would see no reason why it could not require the record to be supplemented as might be necessary").

We find the first rationale supporting primary jurisdiction — the promotion of uniformity and consistency in the regulation of business entrusted to a particular agency — to be unimportant here. The danger of inconsistency present where, for example, various Federal courts construe the provisions of Federal regulatory statutes, is absent in our construction of State law as it applies to a State agency.[3] See Comment, Confusion of Exhaustion of Administrative

[3] In this regard, we note that courts disagree on the question whether referral from a Federal court to a State agency under the primary jurisdiction doctrine is ever appropriate in State action analysis. Contrast *Litton Sys., Inc.* v. *Southwestern Bell Tel. Co.*, 539 F.2d 418, 421 (5th Cir. 1976), with *Industrial Communications Sys., Inc.* v. *Pacific Tel. & Tel. Co.*, 505 F.2d 152 (9th Cir. 1974). See Note, *Parker* v. *Brown* Revisited: The State Action Doctrine Under Goldfarb, Cantor, and Bates, 77 Colum. L. Rev. 898, 925-928 (1977).

Remedies and Primary Jurisdiction Doctrines, 7 Suffolk U.L.Rev. 124, 138-139 (1972).

As to the second rationale supporting the use of primary jurisdiction — reliance on an agency's special expertise, especially with respect to issues involving technical questions of fact — we perceive no lack in the voluminous record before us which could be remedied by any kind of administrative proceeding. The certified questions before us involve questions of law and the application of principles of statutory construction. We agree with the District Court that, in this regard, *Nelson* v. *Blue Shield of Mass., Inc.*, *supra*, is distinguishable. That case involved, among other questions, consideration of the frequency with which Blue Shield's board had been convened, the adequacy of its staff, its technical competence, and the efficiency of its procedures. *Id.* at 753. Such factual questions underlay what amounted to "an attack on the entire system by which Blue Shield compensates participating physicians." *Id.* The certified questions before us, while potentially having a broad impact on the Blue Cross-Blue Shield insurance system, present no such unresolved issues of fact, nor do they involve any claimed violation of the statutes administered by the Commissioner. Accordingly, we see no need to refer to the Commissioner any aspect of the questions certified.

III. *Restriction on "Balance Billing."*

The parties have stipulated that, at present, approximately 96 per cent of all Blue Shield subscribers are covered by "service benefit" contracts, under which a participating physician is required to accept the fee paid by Blue Shield as payment in full for covered services. Thus, only about 4 per cent of subscribers may be billed directly by participating physicians for amounts in addition to Blue Shield's approved rate, or "balance billed", as the plaintiffs term it. The defendants, conceding that no provision of G. L. c. 176B specifically orders this restriction, argue that the statutory purpose of providing low cost medical care, coupled with the Commissioner's regulatory actions in furtherance of that purpose, are together sufficient to insulate the restriction

from Federal antitrust attack. We disagree. Assuming, as we must, that the challenged practice operates to restrain competition in contravention of Federal antitrust law, we find in G. L. c. 176B no affirmative policy requiring, or authorizing the Commissioner to require, such a restraint. We therefore answer question 1(a) in the negative.

The restriction on balance billing is a product of two features of the Blue Shield system. Under the Participating Physician's Agreement presently in use, participating physicians are contractually obligated to accept Blue Shield's fees as payment in full for services rendered to members who are covered by service benefit, as opposed to indemnity benefit, contracts. Historically, as is explained in greater detail later in this opinion, service benefits were available only to subscribers who came within approved income limits. With the advent in 1968 of the "usual and customary charge" method of compensation, however, service benefits were for the first time provided to many subscribers without regard to their income. This development is the focal point of the State action controversy, and we explore it in some detail below.

Blue Shield was incorporated on May 6, 1942, under the name Massachusetts Medical Service. It was the first and remains the only medical service corporation organized under G. L. c. 176B. On September 18, 1942, the Commissioner gave his approval to the first subscription contract, Participating Physician's Agreement, schedule of rates to be charged subscribers, and schedule of fees to be paid participating physicians. The Participating Physician's Agreement, which remains unchanged to the present day, provides that "[t]he Participating Physician agrees to accept as full compensation for all . . . services such payments as are received from the Corporation . . . except in the case of those persons who are entitled only to Limited Indemnification, in which case the physician may make his customary charge to the patient for his services, crediting against such charge the amount set forth for such services in the fee schedule in effect at the time the services are rendered."

The original subscription certificate established two classes of subscribers, "limited" and "unlimited". An unlimited subscriber was one whose annual income was less than a certain amount on file with the Commissioner, a limited subscriber was one whose income exceeded that amount. Income limits were reviewed periodically, and revised to reflect general increases in wages. In 1951, Blue Shield implemented a second plan, known as Plan "B", to supplement the original plan, which was known as Plan "A". Under Plan "B", a single income limit of $5,000 was set for the subscriber and covered dependents; Plan "A" retained separate limits of $2,000 for an individual, $2,500 for families of two, and $3,000 for families of three or more. Plan "B" imposed higher subscription rates and paid higher fees for doctors; essentially, it provided the option of more comprehensive coverage, particularly for higher income subscribers, but did not otherwise depart from the basic precedent of Plan "A".

In 1956, Blue Shield and Blue Cross jointly initiated the Master Medical Certificate, providing comprehensive coverage of hospital and medical costs under a single plan. As with Plan "B", however, there was no departure from the income limit method of determining a subscriber's entitlement to service benefits.

By the late 1960's, there was pervasive dissatisfaction among participating phsyicians with Blue Shield's fees, and particularly with fees received under service benefit contracts. See, e.g., Proceedings of the Massachusetts Medical Society, May 16, 1967. In response to the complaints of participating physicians, Blue Shield in late 1967 or early 1968 filed with the Commissioner a proposed revision of the Master Medical Certificate accompanied by a proposed "Amended Schedule of Benefits — Blue Shield Portion of the Blue Cross — Blue Shield Master Medical Certificate" (1968 Amended Schedule of Benefits). This filing introduced the usual and customary charge method of compensation. Blue Shield proposed to substitute for fixed fee schedules a system under which participating physicians

would receive 95 per cent of the lesser of their usual charge, or the customary charge, for a particular service. The usual charge is calculated by determining the median of all fees charged by a particular physician for a specific service during each six-month reporting period. Similarly, the customary charge is established as the mean of all fees reported for a particular service by physicians of like experience and training during each reporting period.

The advantage to participating physicians in this method of calculating fees lay in the promise of higher fees immediately for many services and relatively automatic future adjustments for inflation. Its benefit to consumers was that, for the first time, participating physicians would be bound to accept Blue Shield's fees as payment in full for covered services regardless of a subscriber's income. When the method was first proposed in 1968, it was to be implemented only for group accounts under the Master Medical Certificate and for Blue Shield's coverage of the Federal Employees program.[4] At present, however, it is applied to all Blue Shield accounts except the few remaining Plan "B" subscribers.

The revisions to the Master Medical Certificate and the 1968 Amended Schedule of Benefits were approved by the Commissioner effective February 1, 1968. From 1970 until 1975, Blue Shield updated usual and customary charges as it deemed appropriate without objection from the Commissioner. In 1976, Blue Shield deferred any update due primarily to a decrease in its reserves from $26 million to $1 million during the eighteen months preceding April 30, 1976. On March 1, 1977, the financial condition of the corporation having improved, Blue Shield filed an amended schedule of benefits. On April 15, 1977, the amended schedule of benefits was approved by the Commissioner subject to the condition that for the 1977 update, "the usual fees and the normal customary fees shall not exceed increases of 107%

[4]The parties offer no estimate of the percentage increase in service benefits at the time this method was instituted.

and 104% respectively, of those fees implemented in July, 1975."[5] In 1978, the Commissioner took the position that any update of usual and customary charges was subject to his prior written approval. A revision to the amended schedule of benefits was filed in 1978 and received preliminary approval, but, following a change in administrations, that approval was rescinded. Accordingly, the 1977 schedule of benefits has remained effective to the present.

The defendants argue that in exercising his power of approval over methods of compensation to achieve the statutory purpose of providing low cost medical care to the public, the Commissioner exerts sufficient control over Blue Shield that the present methods of compensation, and the concomitant limitations on physicians' fees, must be considered to be compelled by a "clearly articulated and affirmatively expressed state policy." There is no simple definition of the degree of State compulsion which will suffice to constitute State action for antitrust purposes. Several of the United States Supreme Court's decisions in which such a policy was found dealt with State schemes with an avowed purpose to restrain competition. See, e.g., *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.*, 445 U.S. 97 (1980); *Bates* v. *State Bar*, 433 U.S. 350 (1977); *Parker* v. *Brown*, 317 U.S. 341 (1943). In this case, however, we are asked to infer such a policy from the broadly stated purpose of G. L. c. 176B and the comprehensive regulatory power of the Commissioner under the statute.

The Supreme Court dealt with an analogous, although not identical, contention in *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579 (1976). There, a retail pharmacist engaged in marketing light bulbs brought suit to enjoin an electric utili-

[5] The 1977 amended schedule of benefits was later challenged in a proceeding instituted by several physicians and the Massachusetts Medical Society. The suit was ultimately dismissed on the ground that the plaintiffs had failed to exhaust their administrative remedies. See *Nelson* v. *Blue Shield of Mass., Inc.*, 377 Mass. 746 (1979).

ty company from distributing to its customers, with no separate charge, approximately fifty per cent of the most commonly used light bulbs. The cost to the utility of maintaining this program was approved by the State public utility commission as one aspect of the tariffs filed by the utility.

The Court formulated the issue tendered in terms of whether "the *Parker* rationale immunizes private action which has been approved by a State and which must be continued while the state approval remains effective." *Id.* at 581. Reversing the United States Court of Appeals for the Sixth Circuit, the Court held that the State's regulatory approval was insufficient to invoke the *Parker* immunity. In its analysis of the case, the Court offered two possible rationales for holding private conduct immune from Federal antitrust attack. First, it noted the potential injustice of holding a private actor liable for simply "[obeying] the command of his state sovereign"; second, the Court suggested that "if the State is already regulating an area of the economy, it is arguable that Congress did not intend to superimpose the antitrust laws as an additional, and perhaps conflicting, regulatory mechanism." *Id.* at 592.

The Court then noted that where the option to initiate the challenged program lay primarily in the private actor's hands, there was no inherent injustice in requiring that the utility conform its conduct to Federal law. *Id.* at 594. Second, and perhaps of more significance to the instant case, the Court found "no logical inconsistency between requiring [the utility] to meet [State] regulatory criteria in so far as it is exercising its natural monopoly powers and also to comply with antitrust standards to the extent that it engages in business activity in competitive areas of the economy." *Id.* at 596. Thus, where the State's regulatory interest could not be considered to extend to the market in light bulbs, the possibility of Federal and State policy conflict was absent. *Id.* at 584-585, 596; see *Bates* v. *State Bar, supra* at 361; *Lafayette* v. *Louisiana Power & Light Co.*, 435 U.S. 389, 419 (1978) (emphasizing the importance of a clearly and affirmatively expressed State policy "requiring the anti-

competitive restraint as part of a comprehensive regulatory system").

In deciding whether Blue Shield's current methods of compensation are compelled by State policy, we understand that we are to look to at least the following factors: any indication that in enacting G. L. c. 176B the Legislature sought to restrain competition in the market for physicians' services; the nature of and extent of the Commissioner's regulatory powers; and the degree to which any State interests involved could be accommodated by a method of compensation with a lesser effect on competition. See, e.g., *Sound, Inc.* v. *American Tel. & Tel. Co.*, 631 F.2d 1324, 1334 (8th Cir. 1980); *George R. Whitten, Jr., Inc.* v. *Paddock Pool Builders, Inc.*, 424 F.2d 25, 30 (1st Cir. 1970). We conclude that, under this analysis, Blue Shield's current method of compensation is not required by any express State policy.

First, to the extent that the Legislature, in enacting G. L. c. 176B, was concerned at all with the market in physicians' services, that concern appears to have been limited to providing a means whereby persons of average and low income could obtain otherwise unaffordable medical care. The clearest indication of this limited purpose is the fact that for the first twenty-six years of its operation, Blue Shield limited service benefits, with the Commissioner's approval, to subscribers who met certain income requirements. It is apparent that neither Blue Shield nor the Commissioner during this period believed that G. L. c. 176B required the extension of service benefits beyond this population.

This limited view of the purpose of G. L. c. 176B is supported by other materials which, while they do not constitute formal legislative history, nevertheless shed light on the contemporary understanding of the Blue Shield program. We have previously relied on such materials in determining legislative intent. See *Pereira* v. *New England LNG Co.*, 364 Mass. 109, 115 (1973).

The draft legislation which was enacted as G. L. c. 176B was introduced by the Massachusetts Medical Society. After

its introduction, the Medical Society observed in its official journal that the legislation was "submitted as evidence of a sincere effort on the part of the Massachusetts Medical Society to meet the present-day problems of low-income groups in regard to paying for medical care." Medical Service Corporations, 224 New England J. Med., No. 3, 124 (1941). In 1962, the Legislature empanelled a "Special Commission to Investigate and Study the Laws relative to Non-Profit Hospital and Medical Service Corporations, and the Rising Cost of Hospital and Medical Care and Hospital Accommodations" (Special Commission); the Special Commission's Final Report was filed in 1964. See 1964 Senate Doc. No. 958. The Special Commission specifically noted that both service and indemnity benefits were contemplated under G. L. c. 176B, and linked the provision of service benefits to Blue Shield's corporate purpose. "Simply stated, the fundamental purpose of . . . Blue Shield is to make available at the lowest possible premium cost, to the average and below average income citizen . . . a plan whereby the medical and surgical needs of himself and his family would be paid for in full at the time of such need." *Id.* at 142. See also *id.* at 182 (recommending that "the service-benefit features of Blue Shield contracts be retained in order to retain its purpose of serving the average and below average income subscribers"). While the Special Commission's report cannot be taken as an indication of original legislative intent, it does reflect the contemporary understanding of the underlying purposes of Blue Shield. The conclusion is inescapable that no one familiar with the legislative scheme, either at its inception or immediately prior to the adoption of the present method of compensation, believed that it required the near universal provision of service benefits which is now subject to challenge.

The second dimension to the defendants' State action argument is that G. L. c. 176B gives the Commissioner pervasive regulatory powers over Blue Shield, and that since 1968 he has exercised those powers to compel the extension of service benefits at their present level. Our review of the

Commissioner's powers convinces us that his approval of the usual and customary method of compensation does not constitute State action for the purposes of antitrust immunity. In *Nelson* v. *Blue Shield of Mass., Inc.*, 377 Mass. 746, 750 (1979), we held that "G. L. c. 176B establishes a comprehensive scheme for the public supervision of medical service corporations." In support of this conclusion, we noted the Commissioner's power of approval over Blue Shield's articles of organization (§ 2), by-laws (§ 3), "the form of its agreements with participating providers and its methods of compensating them (§ 4)," as well as the certificates issued to, and the rates charged, subscribers (§§ 4, 6). *Id.*

By G. L. c. 176B, § 4, the Commissioner is specifically required to approve in writing Blue Shield's "methods of compensating" providers. This language was inserted by St. 1968, c. 432, § 9; prior to this amendment, § 4 required the Commissioner to approve Blue Shield's "rates" of compensation. Under the prior law, we noted that because physician fee schedules are the primary determinants of the rates charged to Blue Shield's subscribers, the express standards governing the Commissioner's approval of rates to subscribers "are implicitly the standards to be applied by the Commissioner . . . in determining the rates at which the physicians are to be compensated. . . . It follows that the Commissioner may disapprove the fee schedule only if the fees are inadequate, excessive or unfairly discriminatory." *Massachusetts Medical Serv.* v. *Commissioner of Ins.*, 344 Mass. 335, 338-339 (1962). There is no reason to think that the substitution, in 1968, of the word "methods" for the word "rates" implied any change in the Commissioner's role under § 4. Thus, following our analysis in *Massachusetts Medical Serv.* v. *Commissioner of Ins.*, *supra* at 339, we think that the present § 4 does not give the Commissioner power to establish Blue Shield's methods of compensation, but only to disapprove them if they are outside the "range of reasonableness." Cf. *Hathaway* v. *Commissioner of Ins.*, 379 Mass. 551, 554 (1980). (St. 1968, c. 432, § 9, indicates no intention to have physicians' fees fixed by the Commissioner.)

The above analysis leads us to the conclusion that although the usual and customary charge method of compensation may represent a reasonable accommodation of the various interests involved in establishing Blue Shield's rates of reimbursement to participating physicians, it is only one among a range of methods that the Commissioner would be required to approve. At least to the extent that it goes beyond the statutory policy of providing service benefits to low income subscribers, it cannot be said to be required by the State. Cf. *Cantor* v. *Detroit Edison Co.*, *supra*, at 584-585.

IV. *Limitation on Payments to Nonparticipating Physicians.*

By contrast to question 1(a), question 1(b) involves a relatively straightforward process of statutory construction. We agree with the defendants that G. L. c. 176B, § 7, precludes payments by Blue Shield to nonparticipating physicians for services rendered to subscribers except in cases of emergency or for services rendered outside the State.

General Laws. c. 176B, § 7, as appearing in St. 1978, c. 574, § 3, provides in relevant part that "[*a*] *subscriber or a covered dependent*, subject to the by-laws, rules and regulations of a medical service corporation and the terms and provisions of his subscription certificate, *shall be entitled to the benefits of this chapter upon receiving medical . . . service from any participating physician . . . or*, in the discretion of the corporation, *upon receiving medical . . . service from any non-participating physician . . . in an emergency or when outside the commonwealth*" (emphasis added). A nonprofit medical service plan is defined by G. L. c. 176B, § 1, as "a plan operated by a medical service corporation . . . whereby the cost of medical . . . service . . . furnished to subscribers and covered dependents is paid by the corporation . . . to participating physicians . . . and to such other physicians as are provided for herein . . . ." Finally, a participating physician is defined as "a registered physician . . . who agrees in writing with a medical service

corporation to perform medical service for subscribers and covered dependents and to abide by the by-laws, rules and regulations of such corporation." G. L. c. 176B, § 1. These sections, read together, indicate a clear legislative purpose to limit the advantages of reimbursement by Blue Shield — principally the guarantee of prompt payment at a fixed rate — to those physicians who choose to participate in the program. The plaintiffs, however, suggest that § 7 merely limits the benefits to which subscribers are entitled, but in no way compels Blue Shield to refuse reimbursement to nonparticipating physicians for nonemergency services rendered in the State.

To the extent that the language of § 7 is ambiguous, the ambiguity is resolved by reference to the structure and history of the Blue Shield program as a whole. The critical language of § 7 was included in the initial bill submitted by the Medical Society to authorize the formation of nonprofit medical service corporations, as well as in the successor bill which was ultimately enacted as G. L. c. 176B. See 1941 House Doc. No. 1477, § 7; 1941 House Doc. No. 2301, § 7. The participating physician concept was integral to the original vision of the manner in which medical service plans would operate. Because medical service corporations were to be formed and operated by the medical profession itself, rather than by commercial insurance companies, the drafters of the enabling legislation were faced with the problem of either accumulating the financial reserves required to guarantee the soundness of the program, or finding some acceptable substitute. This problem was addressed by means of the "unit system," under which participating physicians themselves acted as underwriters of risk.

The system was presented to the Commissioner of Insurance, in a statement from the Medical Society, as a substitute for the reserve requirements of traditional insurance plans. The Medical Society's statement to the Commissioner argued that the unit system "constitutes an actuarial substitute for the necessary large financial reserves

of profit-making commercial corporations . . . . This is necessary in commercial corporations because [financial demands] are directly related to contractually binding, inflexible indemnity schedules. *Thus there is substituted in Massachusetts Medical Service, Inc.* for such large financial reserves, *a guaranteed medical-service reserve* to the subscribers during the terms of the contract, *by participating physicians who accept an unguaranteed and fluctuating schedule of indemnification*, the current monetary equivalent of which at any time is determined by an equitable proration of available earned income among the participating physicians" (emphasis added).

The original Participating Physician's Agreement, approved by the Commissioner of Insurance on September 18, 1942, contained the following clause: "*Unit System*: In the event that the amount available in any accounting period for distribution to Participating Physicians . . . shall be insufficient to pay all Participating Physicians in full, then the amount which the Board of Directors decides is available for distribution shall be paid to all Participating Physicians on a pro rata basis." This agreement remains in use at present.

Obviously, the potential benefits to physicians stemming from participation in the plan were accompanied by an element of risk. Had physicians been free to obtain payment for services to subscribers without incurring the risk of reduced payment under the unit system, there would have been little incentive to participate. Against this background, we think it clear that the Legislature intended by G. L. c. 176B, § 7, to limit Blue Shield's system of reimbursement to participating physicians, except in those circumstances in which such services could not reasonably be obtained.

V. *Blue Cross's Authority to Contract for Payment for Physicians' Services.*

To respond to question No. 2 it will be helpful to recast the question into two questions: (a) Is Blue Cross empowered under G. L. c. 176A to cover physicians' services

under the caption "other health services" as that phrase is used in G. L. c. 176A, § 1? (b) By what authority is Blue Cross authorized to contract directly with the Commonwealth to cover services of physicians?

The first question (a) must be answered "no". Blue Cross was permitted to provide benefits only for hospital services until 1953. In that year the Legislature amended G. L. c. 176A, § 1, to permit a hospital service corporation to provide "reimbursement for other health services." St. 1953, c. 287, § 1. These "other health services" have included such nonhospital providers as visiting nurse associations, mental health clinics and home health agencies. Authorization for these contracts is found in the fourth paragraph of G. L. c. 176A, § 5.

It has been stipulated that Blue Cross has never provided benefits for physicians' services except (1) covered services rendered by salaried staff physicians of hospitals and certain other institutional providers with which it has contracts; and (2) nonemergency, in State service rendered by participating and nonparticipating Blue Shield physicians under the State employees' contract.

The Master Medical Certificate issued to subscribers provides that "[b]enefits contained herein for all services and supplies other than those furnished by a physician, dentist, podiatrist, or psychologist shall be provided by Blue Cross," and that "[b]enefits contained herein for services of a physician, dentist, podiatrist, or psychologist shall be provided by Blue Shield."

It is highly unlikely that the Legislature would authorize Blue Cross and Blue Shield to sail on a collision course of competition for subscribers for coverage of physicians' services when Blue Cross's principal course is directed toward hospital services and Blue Shield's towards physicians' services. Equally improbable is a legislative intent to permit Blue Cross to provide the benefits of a full range of physicians' services on a nonparticipating basis and thereby escape the network of regulation found in G. L. c. 176B. In

short, Blue Cross is not empowered to cover physicians' services except in those instances already noted.

The answer to the second question (b) can be found in G. L. c. 32A, § 4. Blue Cross is authorized to contract with State employees because the Legislature vested it with such authority. Under this statute,[6] the Group Insurance Commission is authorized to enter into an agreement for insurance coverage for State employees with Blue Cross "in the same manner as any other insurance company."

The authority for contracts with State employees reposes in G. L. c. 32A in the first instance, and not in G. L. c. 176A. The express reference to G. L. c. 176A in G. L. c. 32A, § 4, encourages us to rule that such provision is special and thus, absent a contrary legislative intent, it must prevail over conflicting provisions, if any, in G. L. c. 176A and c. 176B. See *Boston Teachers Local 66* v. *School Comm. of Boston*, 370 Mass. 455, 472 (1976). Accordingly, we respond to this question by recognizing that payments to physicians for medical services under the contract between Blue Cross and the Group Insurance Commission are authorized by the express language of G. L. c. 32A, § 4, and, as such, this coverage does not derogate from the exclusiveness of Blue Shield's coverage for physicians' services to subscribers who are not under the contract insuring State employees.

In conclusion, we answer question 1(a), "No", 1(b), "Yes", 2, "No".

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[6]The relevant paragraph of G. L. c. 32A, § 4, as amended through St. 1979, c. 268, § 2, is as follows: "For the purposes of this chapter, any savings bank authorized to engage in the insurance business in accordance with chapter one hundred and seventy-eight and any nonprofit hospital service corporation or nonprofit medical corporation organized under chapter one hundred and seventy-six A or one hundred and seventy-six B shall be and is hereby authorized to enter into a reinsurance agreement as herein provided in the same manner as any other insurance company."

James P. KARTELL, Plaintiff,

v.

BLUE SHIELD OF MASSACHUSETTS, Defendant.

Grant RODKEY, Plaintiff,

v.

BLUE CROSS OF MASSACHUSETTS, Defendant.

Civ. A. Nos. 78-0594-C, 82-0317-C.

United States District Court, D. Massachusetts.

June 30, 1982.

As Amended July 7, 1982.

Various parties moved for summary judgment in suit claiming that agreements between medical insurance plan and participating physicians violated antitrust law. The District Court, Caffrey, Chief Judge, held that state action doctrine barred certain claims but neither state action doctrine nor McCarran-Ferguson Act barred other claims.

Order accordingly.

1. Physicians and Surgeons ⇐21

No state law or policy requires either Commissioner of Insurance or medical insurance plan to prohibit physician from billing patient for fees not paid by medical insurance. M.G.L.A. c. 176B, §§ 3, 4, 7.

2. Monopolies ⇐18

Medical insurance plan's practice of prohibiting physicians from balance billing insured was not shielded from scrutiny under federal antitrust laws under state action doctrine. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176B, §§ 3, 4, 7.

3. Monopolies ⇐18

Medical insurance plan's practice of restricting to participating physicians remuneration for services rendered to subscribers was clearly articulated and affirmatively expressed as state policy, and satisfied first part of state action test. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176B, §§ 3, 4, 7.

4. Monopolies ⇐18

Where medical insurance plan's practice generally excluding nonparticipating physicians from remuneration was compelled by statute, it a fortiori passed second part of state action test and was immune from federal antitrust scrutiny under state action doctrine. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176B, §§ 3, 4, 7.

5. Monopolies ⇐18

In view of explicit language of state statute excluding nonparticipating physicians from remuneration under medical insurance plan, court, in determining whether such practice was protected from antitrust scrutiny under state action doctrine, need not consider test relating to whether challenged restraint is necessary to successful operation of legislative scheme that state sovereign established. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176B, §§ 3, 4, 7.

6. Monopolies ⇐18

Hospital insurance plan's forbearance from generally providing benefits for physician's services was immune under state action doctrine from antitrust challenge. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176A, § 1 et seq.

7. Monopolies ⇐28(7.1)

To establish that agreements between medical insurance plan and its participating physicians were within protection of McCarran-Ferguson Act, plan had burden of showing that agreements were the business of insurance, the agreements must be regulated by state law, and that any agreement to boycott, coerce or intimidate, or act of boycott, coercion, or intimidation was outside Act's exemptive powers and subject to

antitrust laws. McCarran-Ferguson Act, §§ 1–5, 2(b), 15 U.S.C.A. §§ 1011–1015, 1012(b).

8. Monopolies ⇐18

Where participating physicians in medical insurance plan agreed to be compensated for their services rendered to subscribers on pro rata basis if insurer was unable at any time to compensate participating physicians in full because of depletion of funds, there was some amount of risk placed on participating physicians for purpose of determining application of McCarran-Ferguson Act. McCarran-Ferguson Act, §§ 1–5, 2(b), 15 U.S.C.A. §§ 1011–1015, 1012(b).

9. Monopolies ⇐18

Fact that agreements between participating physicians and medical insurance plan required participating physicians to carry some risk was not sufficient to establish that agreements were business of insurance. McCarran-Ferguson Act, §§ 1–5, 2(b), 15 U.S.C.A. §§ 1011–1015, 1012(b).

10. Monopolies ⇐18

Even though agreements between participating physicians and medical insurance plan required physicians to assume some risk by agreeing to be compensated on pro rata basis if plan was unable to compensate in full because of depletion of funds, agreements did not constitute "business of insurance" so as to be exempt from antitrust regulation under McCarran-Ferguson Act. McCarran-Ferguson Act, §§ 1–5, 2(b), 15 U.S.C.A. §§ 1011–1015, 1012(b).

11. Monopolies ⇐18

Agreement whereby participating physicians in medical insurance plan were barred from balance billing subscribers did not rise to level of per se violation of Sherman Act. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

12. Monopolies ⇐12(17)

Per se prohibition of Sherman Act provision making unlawful any contract, combination, or conspiracy in restraint of trade or commerce applies as much to professional services as it does to commodities. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

13. Monopolies ⇐18

Agreements between medical insurance plan and participating physicians should be examined under traditional rules of reason standard to determine whether they violate Sherman Act provision making unlawful contracts, combinations, or conspiracies in restraint of trade or commerce. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

14. Federal Civil Procedure ⇐2546

Sufficient facts had not yet been developed to allow court to make proper determination, under rule of reason standard, of whether agreements between medical insurance plan and participating physicians violated Sherman Act prohibition of agreements in restraint of trade or commerce and motions for summary judgment will be denied and further discovery directed. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

Stanley V. Ragalevsky, Warner & Stackpole, Boston, Mass., David I. Shapiro, Dickstein, Shapiro & Morin, Washington, D. C., for plaintiffs.

Thayer Fremont-Smith, Choate, Hall & Stewart, Boston, Mass., for intervenor-plaintiffs.

Reginald H. Howe, Daniel Mahoney, Palmer & Dodge, Boston, Mass., for Blue Cross and Blue Shield of Mass.

OPINION

CAFFREY, Chief Judge.

This is a private civil antitrust action which was originally filed in March of 1978 by four Massachusetts physicians who request injunctive relief under § 16 of the Clayton Act, 15 U.S.C. § 26, for alleged violations of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2, by Blue Shield of Massachusetts, Inc. (Blue Shield) and Blue Cross of Massachusetts, Inc. (Blue Cross). The Massachusetts Commissioner of Insurance (the Commissioner) intervened as a party defendant, and by order of this Court entered on January 29, 1982, the Massachu-

setts Medical Society (the Society), Grant V. Rodkey and Henry Brown were permitted to intervene "as parties plaintiff in the existing complaint."

In accordance with the suggestion of the Court of Appeals for this Circuit (*Kartell v. Blue Shield of Massachusetts*, 592 F.2d 1191, 1195 (1st Cir. 1979)), in January 1981 the Honorable Walter Jay Skinner of this Court certified certain questions of state law to the Supreme Judicial Court of Massachusetts on a record consisting principally of a Stipulation of Facts and related Exhibits. At that time, Judge Skinner, to whom this case was then assigned, stated that upon his receiving answers to the certified questions, the defendants' pending motion to dismiss would then be treated as a motion for summary judgment to be heard and determined on the same record as the certified questions. In an opinion filed on August 20, 1981, the Supreme Judicial Court answered the certified questions, *Kartell v. Blue Shield of Massachusetts, Inc.*, — Mass. —, Mass.Adv.Sh. (1981) 1980, 425 N.E.2d 213, thus rendering the defendants' motion ripe for hearing and decision as a motion for summary judgment. Plaintiffs Kartell, Wilson and Howe filed a motion for partial summary judgment on March 8, 1982. On April 8, 1982, this Court heard oral arguments on both summary judgment motions.

After considering these arguments, as well as the briefs submitted by all parties, I rule that plaintiffs' complaint against Blue Cross and Blue Shield is barred in part by the state action doctrine of *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943). To the extent that plaintiffs' complaint challenges Blue Shield's "ban on balance-billing," discussed *infra*, the complaint is not barred by either the state action doctrine or the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq*, which exempts from the federal antitrust laws "the business of insurance . . . regulated by State law." *Id.*, § 1012(b). I further rule that the "*per se*" standard of antitrust analysis should not be applied to the so-called ban on balance-billing, and that the traditional "rule of reason" standard should be employed.

As a result of these rulings, it follows that defendants' motion for summary judgment should be granted in part and denied in part, and the plaintiffs' complaint should be dismissed in part with prejudice with respect to all defendants, in accordance with the rulings below. It also follows that plaintiffs' motion for partial summary judgment should be denied.

I. *The Facts*

Although this case has been pending for more than four years, and has been assigned to five different judges of the Court—four of whom have recused themselves—the material facts have not changed since the filing of the complaint or its transfer to the undersigned on March 8, 1982.

Blue Shield and Blue Cross, respectively, are nonprofit, tax-exempt medical service and hospital service corporations, organized to provide "for the preservation of the public health by furnishing medical services at low cost to members of the public who have become subscribers." 1941 Mass.Acts c. 306, preamble. Mass.G.L. c. 176B (Blue Shield); c. 176A (Blue Cross). They are the only corporations of their kind created under their respective enabling statutes.

Blue Shield directly compensates in scheduled amounts those physicians who "participate" in its medical services plan for services rendered to about 96% of Blue Shield's premium-paying subscribers. Participating physicians, in turn, agree to accept Blue Shield's payments in full satisfaction for their services, and not to "balance-bill," *i.e.*, not to seek to recover from Blue Shield subscribers whom they treat any amount in excess of that which Blue Shield has agreed to pay the physician for the service. Except in a few cases not of concern here, Blue Shield does not directly remunerate subscribers in any manner, and does not remunerate non-participating physicians for services rendered to subscribers, unless such services are rendered in an emergency, or outside the Commonwealth.

Blue Cross, on the other hand, is authorized by statute to provide coverage to its subscribers for hospital care and related procedures. Blue Cross does not remunerate any physician for services rendered to Blue Cross subscribers except those physicians who are salaried members of the staffs of institutions, like hospitals, which have entered into agreements with Blue Cross, and those physicians who treat Massachusetts state employees who are subscribers of a Blue Cross plan available only to employees of the Commonwealth.

As permitted by Mass.G.L. c. 176B, § 3, Blue Shield has joined with Blue Cross for the joint administration of their affairs and the issuance of joint subscriber contracts for both medical and hospital services. At this time, defendants' subscribers constitute about 60% of the population of Massachusetts, and about 99% of the Commonwealth's physicians are participating physicians in Blue Shield's medical service plan.

The doctors who are the individual plaintiffs here are all licensed to practice medicine in Massachusetts. All but two are participants in Blue Shield's medical service plan, and all claim to have been materially harmed by certain practices of Blue Cross and Blue Shield.

Specifically, plaintiffs claim that Blue Shield is engaged in illegal price fixing 1) by generally refusing to reimburse physicians who have not signed participating Physicians' Agreements with Blue Shield for services rendered to Blue Shield subscribers, and 2) by requiring that participating physicians (a) accept Blue Shield's reimbursement as payment in full in most cases, and (b) refrain from billing Blue Shield subscribers for any amount in excess of the amount which Blue Shield has agreed to pay participating physicians. Plaintiffs claim that were it not for Blue Shield's so-called ban on balance-billing, participating physicians would be able in many cases to charge and receive higher fees for their services to subscribers. They also claim that Blue Shield's refusal in most cases to compensate either subscribers or non-participating physicians for services rendered by non-participating physicians wrongfully deprives those physicians of potential patients who, but for Blue Shield's policy of excluding non-participating physicians, would turn to non-participating physicians for treatment.

Plaintiffs further allege that Blue Cross has agreed with Blue Shield to refuse to provide benefits to Blue Cross subscribers for services rendered by physicians other than those rendered by the salaried staff of institutional providers, such as hospitals, and those rendered under Blue Cross' contract covering Massachusetts State employees. Plaintiffs claim that this agreement has had the effect of perpetuating Blue Shield's alleged dominance in the market of providing insurance against the costs of physicians' services.

Plaintiffs further allege that Blue Shield directs its subscribers not to use non-participating physicians, and directs participating physicians not to refer patients to non-participating physicians. Blue Cross, according to plaintiffs, directs its participating hospitals not to employ physicians who do not participate in the Blue Shield plan.

II. *The State Action Exemption*

Judge Skinner initially dismissed the complaint in April 1978 on the ground that the challenged practices are immune from federal antitrust attack under the "state action" exemption recognized in *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943).[1] Recognizing that application of the state action doctrine to the facts of this case called for the "[r]esolution of . . . complex questions of state law," the United States Court of Appeals for the First Circuit reversed the ruling dismissing the complaint and instructed Judge Skinner to seek state court guidance in determining the an-

1. "In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress." *Parker v. Brown*, 317 U.S. 341, 351, 63 S.Ct. 307, 313, 87 L.Ed. 315 (1943).

swers to these questions, first, by awaiting a forthcoming decision in a related case then pending before the Massachusetts Supreme Judicial Court,[2] and second, if that decision did not present sufficient guidance, to consider "certifying" the relevant questions of state law to the Supreme Judicial Court for that court's consideration. As noted above, questions of state law were eventually certified by Judge Skinner to the Commonwealth's highest court, and were answered by that court in an opinion announced on August 20, 1981. The answers to these questions now enable this Court to determine whether the challenged practices of Blue Shield and Blue Cross constitute "state action," and thus are immune from attack under the federal antitrust laws.

As all parties have noted in their arguments, the state action defense originally announced in *Parker* has been reviewed and restated in two recent decisions of the Supreme Court: *Community Communications Company Inc. v. City of Boulder, Colo.*, —— U.S. ——, ——, 102 S.Ct. 835, 839, 70 L.Ed.2d 810 (1982), and *California Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 100 S.Ct. 937, 63 L.Ed.2d 233 (1980). The standard articulated in *Midcal*, which was expressly reaffirmed in *Community Communications*, is as follows:

> First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy;' second, the policy must be 'actively supervised by the State itself.'

445 U.S. at 105, 100 S.Ct. at 943 (citations omitted). As noted above, plaintiffs have identified several practices which they claim amount to illegal restraints. The answer of the Supreme Judicial Court to the certified questions clearly disclose whether three of the challenged restraints are "clearly articulated and affirmatively expressed as state policy," and thus meet the first part of the state action test.

II(A). *Question 1(a): The Ban on Balance-Billing*

The first question certified to and answered by the Supreme Judicial Court asks:

> 1. Is Blue Shield of Massachusetts, Inc. compelled by M.G.L. c. 176B, § 7 or any other Massachusetts statute or required by a clearly articulated and affirmatively expressed State policy (a) to limit fees of participating physicians as described in the Annexed Stipulation [*i.e.*, by requiring the participating physician to accept the fee paid by Blue Shield as payment in full for covered services rendered to Blue Shield subscribers] . . .?

The Supreme Judicial Court ruled that "we find in G.L. c. 176B no affirmative policy requiring, or authorizing the Commissioner to require, such a restraint. We therefore answer question 1(a) in the negative." *Kartell, supra*, —— Mass. at ——, Mass.Adv.Sh. (1981) at 1986, 425 N.E.2d 313.

The court's exhaustive rationale for its answer to question 1(a) includes a concise history of the fee-limitation practice, *Id.* at ——, Mass.Adv.Sh. (1981) at 1986–94, 425 N.E.2d 313, which was culled from the same Stipulation of Facts and Exhibits now before this court, and which merits paraphrase here.

Blue Shield was incorporated as the first and only medical service corporation organized under G.L. c. 176B on May 6, 1942. On September 18, 1942, the Commissioner, pursuant to his powers under c. 176B, gave his approval to the first subscription contract, the first Participating Physician's Agreement,[3] the first schedule of rates to be

2. In this case, *Nelson v. Blue Shield of Massachusetts*, 377 Mass. 746, 387 N.E.2d 589 (1976), the Supreme Judicial Court dismissed the complaint on the grounds that plaintiffs there had failed to exhaust their administrative remedies.

3. This agreement, which remains unchanged to this date, provides in relevant part that:

> "[t]he Participating Physician agrees to accept as full compensation for all . . . services such payments as are received from the Corporation . . . except in the case of those persons who are entitled only to Limited Indemnification, in which case the physician may make his customary charge to the patient for his services, crediting against such charge the amount set forth for such services in the

charged subscribers, and the first schedule of fees to be paid participating physicians. The original subscription certificate created two classes of subscribers, "unlimited" (those whose personal or family income was below a certain figure, who received under the plan "unlimited" coverage from physicians in return for their premium payments), and "limited" (those whose income was above a certain figure who could be "balanced-billed" by participating physicians for charges in excess of that amount which Blue Shield had agreed to pay participating physicians). In 1951, the "unlimited" class of subscribers was divided into two sub-classes. The sub-class whose membership had higher incomes than those of the lower sub-class also were charged higher premiums; participating physicians received higher payments from Blue Shield for services rendered to subscribers in the higher income group. This subdivision of the "unlimited" group did not affect participating physicians' ability to balance-bill limited subscribers.

In 1956, Blue Cross and Blue Shield initiated the Master Medical Certificate, which provides comprehensive coverage of hospital and medical costs under a single plan, but which did not depart from the income-limit method of determining a subscriber's entitlement to service benefits.

In late 1967, Blue Shield submitted to the Commissioner a proposed "Amended Schedule of Benefits—Blue Shield Portion of Blue Cross—Blue Shield Master Medical Certificate," which introduced the "usual and customary charge" method of compensation. According to the Supreme Judicial Court,

> Blue Shield [by this plan] proposed to substitute for fixed fee schedules a system under which participating physicians would receive 95 percent [5 percent would be subtracted by Blue Shield to cover administrative costs] of the lesser of their usual charge, or the customary charge, for a particular service. The usual charge is calculated by determining the median of all fees charged by a particular physician for a specific service during each six month reporting period. Similarly, the customary charge is established as the mean of all fees reported for a particular service by physicians of like experience and training during each reporting period.

Id. at ——, Mass.Adv.Sh. (1981) at 1987–88, 425 N.E.2d 313. While participating physicians under the usual and customary method of compensation are required to accept Blue Shield's fees as payment in full for covered services regardless of a subscriber's income, the advantage to participating physicians of this system (at least in the late 1960s, when lagging Blue Shield fee adjustments were reducing physicians' real compensation because of inflation) was the "promise of higher fees immediately for many services and relatively automatic future adjustments for inflation." *Id.* at ——, Mass.Adv.Sh. (1981) at 1988, 425 N.E.2d 313.

The Commissioner approved the revision of the Master Medical Certificate effective February 1, 1968, and through 1975 Blue Shield "updated usual and customary charges as it deemed appropriate without objection from the Commissioner." *Id.* In 1976, no updating was proposed by Blue Shield due to the fact that its reserves had decreased from $26 million to $1 million during the eighteen months preceding May of 1976. Blue Shield proposed an update of the charges in 1977, which was approved by the Commissioner subject to the qualification that increases in the usual and customary fees not exceed 7 and 4 percent, respectively. In 1978, the Commissioner took the position that updates in the usual and customary fees must receive his prior written approval, which was withheld for the 1978 proposed increases. Thus, the 1977 fee schedules have remained in effect to this date.

In answering question 1(a), the Supreme Judicial Court focused on two elements. The court first examined the language and statutory history of Mass.G.L. c. 176B, and

fee schedule in effect at the time the services are rendered."

arrived at the "inescapable" conclusion that "no one familiar with the legislative scheme, either at its inception or immediately prior to the adoption of the present method of compensation, believed that it required the near universal provision of service benefits [*i.e.*, the ban on balance-billing] which is now subject to challenge." The Supreme Judicial Court thus ruled that Blue Shield's near-universal ban on balanced-billing was nowhere "compelled" by the statute in question.

The Supreme Judicial Court similarly found that because § 4 of c. 176B gives the Commissioner the power only to *disapprove* of Blue Shield's methods of compensation if they are outside the range of reasonableness, but not to establish those methods, the Commissioner's "approval in 1967 of the usual and customary method of compensation does not constitute State action for the purposes of anti-trust immunity." *Id.* at ——, Mass.Adv.Sh. (1981) at 1993, 425 N.E.2d 313.

Defendants here do not challenge the Supreme Judicial Court's negative answer to question 1(a) as that question was put to the court. They rather contend that the Supreme Judicial Court's rationale requires a finding by this Court that a method of compensation which prohibits participating physicians from balance-billing low- and middle-income subscribers (who the Supreme Judicial Court has ruled were intended by the legislature to be the beneficiaries of c. 176B) is compelled by the statute or by state policy as articulated and implemented by the Commissioner. The defendants' reading of the Supreme Judicial Court's rationale, if accepted, would insulate from antitrust challenge the usual and customary method of compensation as it pertains to low- and middle-income subscribers, leaving for antitrust scrutiny only that part of the method which applies to upper-income subscribers.

[1, 2] I decline to adopt the defendants' contention. While it is beyond doubt that Mass.G.L. c. 176B is primarily intended to insure that affordable health insurance will be available to low- and middle- income residents of the Commonwealth, I find no state law or policy which requires either the Commissioner or Blue Shield to prohibit balance-billing for *any* income-class of subscribers. I adopt the rationale of the Supreme Judicial Court, and rule that no " 'clearly articulated and affirmatively expressed . . . state policy,' " *Midcal, supra*, 445 U.S. at 105, 100 S.Ct. at 943, compells the use by Blue Shield of the usual and customary charge method of compensation to participating physicians. As a result, I rule that this practice cannot be shielded from scrutiny under the federal antitrust laws under the state action doctrine of *Parker* and *Midcal*.

II(B). *Question 2(a): The "lock-out" of non-participating Physicians*

The second question certified to the Supreme Judicial Court asks:

> 1. Is Blue Shield of Massachusetts, Inc., compelled by M.G.L. c. 176B, § 7 or any other Massachusetts statute or required by any clearly articulated and affirmatively expressed State policy . . . (b) to refuse to make payment for non-emergency services provided in Massachusetts by physicians who decline to accept the terms imposed by Blue Shield in their participation agreement, including limitation of such fees?

Finding that "[b]y contrast to question 1(a), question 1(b) involves a relatively straightforward process of statutory construction," —— Mass. ——, (1981) Mass.Adv.Sh. at 1994, 425 N.E.2d 313, the Supreme Judicial Court ruled "that G.L. c. 176B, § 7, precludes payments by Blue Shield to non-participating physicians for services rendered to subscribers except in cases of emergency or for services rendered outside the State." *Id.*

The Supreme Judicial Court explained its ruling in the following passage:

> General Laws, c. 176B, § 7, as appearing in St. 1978, c. 574, § 3 provides in relevant part that "*[a] subscriber or a covered dependent*, subject to the by-laws, rules and regulations of a medical service corporation and the terms and provisions of his subscription certificate, *shall be*

entitled to the benefits of this chapter upon receiving medical . . . service from any participating physician . . . or, in the discretion of the corporation, *upon receiving medical . . . service from any non-participating physician . . . in an emergency or when outside the Commonwealth*" (emphasis added). A nonprofit medical service plan is defined by G.L. c. 176B, § 1, as "a plan operated by a medical service corporation . . . whereby the cost of medical . . . service . . . furnished to subscribers and covered dependents is paid by the corporation . . . to participating physicians . . . and to such other physicians as are provided for herein . . ." Finally, a participating physician is defined as "a registered physician . . . who agrees in writing with a medical service corporation to perform medical service for subscribers and covered dependents and to abide by the by-laws, rules and regulations of such corporation." G.L. c. 176B, § 1. These sections, read together, indicate a clear legislative purpose to limit the advantages of reimbursement by Blue Shield—principally the guarantee of prompt payment at a fixed rate—to those physicians who choose to participate in the program.

The Supreme Judicial Court analyzed and rejected the plaintiffs' argument that § 7 of c. 176B merely limits the benefits to which subscribers are entitled, but in no way compels Blue Shield to refuse reimbursement to non-participating physicians for non-emergency services rendered in the Commonwealth.[4] In rejecting this argument, the Court discussed the origins of Blue Shield, highlighting matters of significance to this and later parts of this opinion. The Supreme Judicial Court said:

> To the extent that the language of § 7 is ambiguous, the ambiguity is resolved by reference to the structure and history of the Blue Shield program as a whole. The critical language of § 7 was included in the initial bill submitted by the Medical Society to authorize the formation of nonprofit medical service corporation, as well as in the successor bill which was ultimately enacted as G.L. c. 176B. The participating physician concept was integral to the original vision of the manner in which medical service plans would operate. Because medical service corporations were to be formed and operated by the medical profession itself, rather than by commercial insurance companies, the drafters of the enabling legislation were faced with the problem of either accumulating the financial reserves required to guarantee the soundness of the program, or finding some acceptable substitute. This problem was addressed by means of the "unit system", under which participating physicians themselves acted as underwriters of risk.
>
> The system was presented to the Commission of Insurance, in a statement from the Medical Society, as a substitute for the reserve requirements of traditional insurance plans. The Medical Society's statement to the Commissioner argued that the unit system "constitutes an actuarial substitute for the necessary large financial reserves of profit-making commercial corporations . . . This is necessary in commercial corporations because [financial demands] are directly related to contractually binding, inflexible indemnity schedules. Thus there is substituted in Massachusetts Medical Service, Inc. [now known as Blue Shield of Massachusetts, Inc.] for such large financial reserves, a guaranteed medical-service reserve to the subscribers during the terms of the contract, by participating physicians who accept an unguaranteed and fluctuating

4. After having argued to the Supreme Judicial Court that c. 176B, § 7, prohibits the payment of benefits to *subscribers*, and *not* to non-participating physicians, plaintiffs argue before this court that c. 176B, § 7, prohibits the payment of benefits to *non-participating physicians*, but does not prohibit the payment of benefits to subscribers for services rendered by non-participating physicians. I rule that such an attempted end around reverse of the Supreme Judicial Court's clearly-reasoned answer to the question put to it by this Court should be stopped with no gain, for the Supreme Judicial Court's rationale, which is quoted in the body of this opinion, disposes of *both* of plaintiffs' argument on this issue.

schedule of indemnification, the current monetary equivalent of which at any time is determined by an equitable proration of available earned income among the participating physicians" (emphasis added).

The original Participating Physician's Agreement, approved by the Commissioner of Insurance on September 18, 1942, contained the following clause: "Unit System: In the event that the amount available in any accounting period for distribution to Participating Physicians . . . shall be insufficient to pay all Participating Physicians in full, then the amount which the Board of Directors decides is available for distribution shall be paid to all Participating Physicians on a pro rata basis." This agreement remains in use at present.

Obviously, the potential benefits to physicians stemming from participation in the plan were accompanied by an element of risk. Had physicians been free to obtain payment for services to subscribers without incurring the risk of reduced payment under the unit system, there would have been little incentive to participate.

Id. at —, Mass.Adv.Sh. (1981) at 1995–96, 425 N.E.2d 313. The Supreme Judicial Court concluded its analysis of question 1(b) by stating that "[a]gainst this background, we think it clear that the Legislature intended by G.L. c. 176B, § 7, to limit Blue Shield's system of reimbursement to participating physicians, except in those circumstances in which such services could not reasonably be obtained." *Id.* at —, Mass. Adv.Sh. (1981) at 1996, 425 N.E.2d 313.

[3] In light of this controlling interpretation of state law made by the highest court of the Commonwealth, I rule that Blue Shield's practice of restricting to participating physicians remuneration for services rendered to subscribers is " 'clearly articulated and affirmatively expressed as state policy,' " *Midcal, supra*, at 105, 100 S.Ct. at 943, and therefore satisfies the first part of the state action test.

The intervenor plaintiffs claim that Blue Shield's general practice of not remunerating non-participating physicians cannot pass the second part of the state action test, which requires that the challenged restraint "be 'actively supervised' by the State itself." *Id.* They claim that their argument is supported by the fact that Blue Shield subscriber contracts provide that remuneration will be provided to non-participating physicians in the event of emergency, or for services rendered outside of Massachusetts, and then only when the services of a participating physician are not reasonably available, and at the discretion of Blue Shield. There is, however, nothing in plaintiffs' complaint which shows that they are challenging under the antitrust laws the procedure by which Blue Shield determines whether services rendered to a subscriber by a non-participant were rendered in an emergency situation or out-of-state, or whether the services of a participating physician was not reasonably available. Plaintiffs instead are challenging the larger Blue Shield practice of normally remunerating only participating physicians.

[4, 5] I rule that since the challenged Blue Shield practice of generally excluding non-participating physicians from remuneration is compelled by c. 176B, § 7, it a *fortiori* passes the second part of the state action test, and is as a result immune from federal antitrust scrutiny under the state action doctrine of *Parker, supra*, and its progeny. Plaintiffs argue that in *Corey v. Look*, 641 F.2d 32 (1st Cir. 1981) the United States Court of Appeals for the First Circuit recently articulated a third rung of the state action test which requires that "the [entity] . . . claiming [state action] exemption illustrate the requisite state legislative intent by demonstrating by convincing reasoning that the challenged restraint is necessary to the successful operation of the legislative scheme that the state sovereign has established." The court in *Corey* ruled that this showing must be made only in cases where "explicit" statutory language was "absent." *Id.* Given the clear language of c. 176, § 7, and the state court's finding that "question 1(b) involves a relatively straightforward process of statutory

construction," I rule that the test articulated in *Corey* need not be considered herein.

Insofar as plaintiffs' complaint challenges this Blue Cross practice, the complaint should be dismissed.

II(C). *Question 2: Blue Shield Forebearance From Generally Providing Benefits for Physician's Services*

The third question certified to the Supreme Judicial Court asks:

> 2. Is Blue Cross of Massachusetts, Inc. permitted generally under the Massachusetts statutes to make payments to subscribers or physicians for medical services provided by physicians to Blue Cross-Blue Shield subscribers, as it does under its contract insuring employees of the Commonwealth?

One of plaintiffs' theories in this law suit is that Blue Cross has failed to generally provide coverage for its subscribers for services rendered by physicians, other than those services rendered by the salaried staff of institutional providers such as hospitals. Plaintiffs suggest that this failure suggests the existence of an illegal conspiracy between Blue Cross and Blue Shield which allows Blue Shield to dominate the market of health insurance for treatment by physicians. That Blue Cross could offer such coverage under its enabling laws, according to plaintiffs, is demonstrated by the fact that such coverage is provided for those Blue Cross subscribers who are employees of the Commonwealth.

[6] In ruling that the laws of Massachusetts do *not* generally permit such coverage, the Supreme Judicial Court articulated the following rationale, which I adopt:

> To respond to Question No. 2 it will be helpful to recast the question into two questions: (a) Is Blue Cross empowered under G.L. c. 176A to cover physicians' services under the caption "other health services" as that phrase is used in G.L. c. 176A, § 7? (b) By what authority is Blue Cross authorized to contract directly with the Commonwealth to cover services of physicians?

The first question (a) must be answered "no." Blue Cross was permitted to provide benefits only for hospital services until 1953. In that year the Legislature amended G.H. c. 176A, § 1, to permit a hospital service corporation to provide "reimbursement for other health services." St. 1953, c. 287, § 1. These "other health services" have included such non-hospital providers as visiting nurse associations, mental health clinics and home health agencies. Authorization for these contracts is found in the fourth paragraph of G.L. c. 176A, § 5.

It has been stipulated that Blue Cross has never provided benefits for physicians' services except (1) covered services rendered by salaried staff physicians of hospitals and certain other institutional provides with which it has contracts; and (2) nonemergency, in-State service rendered by participating and non-participating Blue Shield physicians under the State employees' contract.

The Master Medical Certificate issued to subscribers provides that "[b]enefits contained herein for all services and supplies other than those furnished by a physician, dentist, podiatrist, or psychologist shall be provided by Blue Cross," and that "[b]enefits contained herein for services of a physician, dentist, podiatrist, or psychologist shall be provided by Blue Shield."

It is highly unlikely that the Legislature would authorize Blue Cross and Blue Shield to sail on a collision course of competition for subscribers for coverage of physicians' services when Blue Cross's principal course is directed towards hospital services and Blue Shield's towards physicians' services. Equally improbable is a legislative intent to permit Blue Cross to provide the benefits of a full range of physicians' services on a non-participating basis and thereby escape the network of regulation found in G.L. c. 176B. In short, Blue Cross is not empowered to cover physicians' services except in those instances already noted.

The answer to the second question (b) can be found in G.L. c. 32A, § 4. Blue Cross

is authorized to contract with State employees because the Legislature vested it with such authority. Under this statute, the Group Insurance Commission is authorized to enter into an agreement for insurance coverage for State employees with Blue Cross "in the same manner as any other insurance company."

The authority for contracts with State employees reposes in G.L. c. 32A in the first instance, and not in G.L. c. 176A. The express reference of G.L. c. 176A in G.L. c. 32A, § 4 encourage us to rule that such provision is special and thus, absent a contrary legislative intent, it must prevail over conflicting provisions, if any, in G.L. c. 176A and c. 176B. . . . Accordingly, we respond to this question by recognizing that payments to physicians for medical services under the contract between Blue Cross and the Group Insurance Commission are authorized by the express language of G.L. c. 32A, § 4, and, as such, this coverage does not derogate from the exclusiveness of Blue Shield's coverage for physicians' services to subscribers who are not under the contract insuring State employees.

Id. at ——-——, Mass.Adv.Sh. (1981) at 1996–1998, 425 N.E.2d 313. Since general forebearance from the insurance market covering physician's services is clearly required of Blue Cross by state statutes as described above by the Supreme Judicial Court, I rule that this practice satisfies both prongs of the *Midcal* test, and thus is immune under the state action doctrine from antitrust challenge.[5] Thus plaintiffs' complaint should be dismissed insofar as it challenges Blue Cross' forebearance from this market.

III. *The McCarran-Ferguson Act*

Since this Court has ruled that the agreement of Blue Shield and participating physicians to use the usual and customary method of physician compensation is not immune from antitrust scrutiny under the state action doctrine, we now turn to defendants' claim that this agreement is exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015.

[7] To establish that the agreements between Blue Shield and its participating physicians are within the protection of the Act, Blue Shield has the burden of meeting three separate tests. First, the agreements must be shown to be the "business of insurance," 15 U.S.C. § 1012(b), as that statutory term has been interpreted by case law since the passage of the Act 40 years ago. Second, the agreements must be "regulated by State law" as required by § 2(b) of the Act. *Id.* Third, "any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation" is outside the Act's exemptive powers, and remains subject to the antitrust laws. The undisputed facts at this point must show an absence of any such agreement or action before the defendants may be awarded summary judgment on this issue.

Plaintiffs claim that a recent Supreme Court case, *Group Life and Health Insurance Company v. Royal Drug Company*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979), clearly establishes that the agreements in question here are not the "business of insurance" as required by the Act. The Supreme Court in that case was confronted with a scheme whereby Blue Shield of Texas offered insurance policies which entitled the policyholder to obtain prescription drugs from both participating and non-participating pharmacies. If a prescription were obtained under this plan from a participating pharmacy, the insured paid $2 to the pharmacy for the prescription; the pharmacy's wholesale cost was paid to the participating pharmacy directly by Blue Cross. Thus the highest price a participating pharmacy could obtain on prescription sold to a Blue Shield policyholder was its wholesale cost plus $2. If the prescription were obtained from a non-participating pharmacy, the insured paid the entire price charged by the pharmacy to the pharmacy, and was reimbursed by Blue Shield for 75% of the difference between the actual price

5. *See* discussion of *Corey v. Look*, *supra*.

and $2. Thus non-participating pharmacies were not limited in the amount that they could charge Blue Shield subscribers.

Suit was brought against Blue Shield by a group of pharmacy owners who alleged that the agreements entered into by Blue Shield and the participating pharmacies amounted to the type of price fixing banned by § 1 of the Sherman Act. The United States District Court for the Western District of Texas granted summary judgment to Blue Shield on the grounds that the agreements met all three tests of the McCarran-Ferguson Act. Upholding the reversal of the trial court by the United States Court of Appeals for the Fifth Circuit, the Supreme Court ruled that the agreements in fact did not amount to the "business of insurance," and thus were not within the protection of the Act. *Id.* at 211–15, 99 S.Ct. at 1073–1075.

In so holding, the Court articulated what amounts to a two part test that procurement agreements similar to the one examined in *Royal Drug* must meet in order to be considered the "business of insurance." First, the agreement must be concerned in part with the "spreading and underwriting of a *policyholder's* risk." *Id.* at 211, 99 S.Ct. at 1073 (emphasis added). Second, since the "business of insurance" is "commonly understood" to focus on " 'the relationship between the insurance company and the policyholder' ", *Id.* at 215–16, 99 S.Ct. at 1075, *quoting SEC v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 568, 21 L.Ed.2d 668 (1969), the agreements must themselves focus at least in part on the relationship between the insured and the insurer, and not merely on contractual arrangements for the procurement of goods and services.

The Court ruled that the agreement between Blue Shield of Texas and participating pharmacies could not pass either test, and thus were not part of the "business of insurance." The agreements, the Court said, "serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations" to its policyholders. *Id.* at 213, 99 S.Ct. at 1074. As long as Blue Shield is able to keep its contractual obligation to its policyholders that they will not have to pay more than $2 per prescription to participating pharmacies, "policyholders are basically unconcerned with the arrangements made between Blue Shield and participating pharmacies." *Id.* at 214, 99 S.Ct. at 1074. The court continued:

> By agreeing with pharmacies on the maximum price it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The Agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost-saving arrangements may well be sound business practice, and may well insure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the business of insurance.

Id.

[8] The agreements between Blue Shield and participating physicians challenged here by plaintiffs are in substance the same as those agreements which were ruled to be outside the realm of the "business of insurance" in *Royal Drug*, with one exception—a difference which Blue Shield argues brings these agreements within the *Royal Drug* definition of the "business of insurance." As was described in detail by the Supreme Judicial Court of Massachusetts in excerpts from its *Kartell* decision reproduced above, the "unit system," by which participating physicians agree to be compensated for their services rendered to Blue Shield subscribers on a *pro rata* basis if Blue Shield is unable at any time to compensate participating physicians in full because of a depletion of Blue Shield funds, has been an integral part of the agreement between Blue Shield and participating physicians since the creation of Blue Shield 40 years ago. Blue Shield argues that "[u]nlike the pharmacy agreements at issue in *Royal Drug*, Blue Shield's agreements with its participating physicians [by inclusion of the unit system] place underwriting risk on the physicians." Plaintiffs counter that the "unit system" is a "relic" of the early years of Blue Shield, and make much

of the fact that Blue Shield has never in its history had to resort to *pro rata* compensation because of a depletion of its funds. I concur with Blue Shield and the Supreme Judicial Court that the unit system remains an integral part of the larger Blue Shield plan, and continues to place some amount of risk on participating physicians. That this risk is perhaps a significant risk is underscored by the fact that, as noted above, Blue Shield in 1976 made the decision not to upscale its usual and customary fee schedule in 1976 due to the fact that its funds available for physician compensation had dramatically dropped from $26 million to $1 million in an 18-month period.

[9, 10] I further rule that the fact that the "unit system" forces participating physicians to carry some risk is not enough by and of itself to satisfy the first test of *Royal Drug*. The risk accepted by the participating physicians is the risk that at any time Blue Shield may not have sufficient reserves to satisfy participating physicians' claims for remuneration. This is a risk which, absent the participating physicians' agreement to carry it, would be carried by Blue Shield, not by the subscribers. By agreeing to carry the risks inherent in the "unit system," participating physicians no doubt enable Blue Shield to cut the costs of maintaining the higher reserves that private insurance companies not able to employ the unit system must maintain. As is noted above, this is the result the Supreme Judicial Court found was intended by the state legislature in including the unit system in c. 176B. And it is also true that these lower costs may result in lower subscriber premiums. But the Supreme Court has ruled in *Royal Drug* that the fact that an agreement between an insurance company and a third party may result in lower premiums to policyholders is not enough to qualify that agreement as the "business of insurance." As the court stated, "The [McCarran-Ferguson Act] exemption is for the 'business of insurance,' not the 'business of insurers.'" *Id.* at 211, 99 S.Ct. at 1073. I therefore rule that the agreements here in question between Blue Shield and participating physicians do not qualify as the "business of insurance," and thus are not exempt from the federal antitrust laws under the McCarran-Ferguson Act.

IV. *Plaintiffs' Motion for Partial Summary Judgment*

Plaintiffs claim that the general ban on balance-billing contained in Blue Shield's agreements with its participating physicians constitutes a violation of § 1 of the Sherman Act, and have moved for partial summary judgment on this issue pursuant to Fed.R.Civ.P. 56. The question of whether agreements such as the one examined here are violations of § 1 is currently being litigated in at least two other federal courts (see discussion below), and the Supreme Court recently stated that it has not yet been presented with this exact question, and thus has not yet expressed an opinion on whether these agreements are in violation of the Sherman Act. *Arizona v. Maricopa County Medical Society*, —— U.S. ——, 102 S.Ct. 2466, 73 L.Ed.2d 48 (1982), Opinion of the Court, n.26.

[11] After considering all of the parties' oral arguments and briefs on this issue, I rule that this agreement does not rise to the level of a *per se* violation of the Sherman Act, and that the facts have not been sufficiently developed at this point in time to allow a proper determination to be made as whether the agreement violates the "rule of reason" standard which more commonly is used to determine violations of § 1. Consequently, plaintiffs motion for partial summary judgment should be denied.

[12] The words of § 1 of the Sherman Act make unlawful "[e]very contract, combination . . ., or conspiracy, in restraint of trade or commerce among the several States." 15 U.S.C. § 1. Plaintiffs' primary theory of Blue Shield's § 1 liability is that the ban on balance-billing is *per se* violative of § 1. Antitrust case law has determined that restrictive agreements which are "manifestly anticompetitive" are violative *per se* of § 1. *See, e.g., Continental T.V. Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36,

49–50, 97 S.Ct. 2549, 2557, 53 L.Ed.2d 568 (1977); *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 5, 78 S.Ct. 514, 518, 2 L.Ed.2d 545 (1958). Plaintiffs here claim that the agreements between Blue Shield and its participating physicians are similar to agreements which have been struck down by the Supreme Court as "manifestly anticompetitive" despite the fact that the agreements set maximum as opposed to minimum prices at which the goods in question may be sold to third parties. *Albrecht v. Herald Co.*, 390 U.S. 145, 88 S.Ct. 869, 19 L.Ed.2d 998 (1968) (publisher's establishment of maximum resale price of newspapers sold by carriers held *per se* violative of § 1); *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 71 S.Ct. 259, 95 L.Ed. 219 (1951) (distiller's agreement on maximum resale price of liquor sold by distillers held *per se* violative of § 1). Plaintiffs correctly point out that the *per se* prohibition of § 1 applies as much to professional services such as medical treatment as it does to the "commodities" involved in the cases cited above. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 786–788, 95 S.Ct. 2004, 2013, 44 L.Ed.2d 572 (1975).

Blue Shield, on the other hand, argues that the *per se* standard should not be applied to its agreements with participating physicians, and relies for support on recent cases from the United States Court of Appeals for the Second Circuit and the United States District Court for the Northern District of California. In *Medical Arts Pharmacy v. Blue Cross & Blue Shield of Connecticut*, 675 F.2d 502 (2d Cir. 1982), the Court of Appeals for the Second Circuit upheld a decision of the United States District Court for the District of Connecticut by ruling that agreements between Blue Cross and participating pharmacies in which the maximum prices that the pharmacies could charge Blue Cross subscribers was set were not *per se* violative of § 1. The agreements in this case were almost duplicates of the agreements examined by the Supreme Court in the *Royal Drug* case, discussed above, in that Blue Cross subscribers who patronized "participating" pharmacies (*i.e.*, those who had entered into agreement with Blue Cross) were required at most to pay the pharmacy a small "deductible" amount, and the pharmacy was reimbursed by Blue Cross at the rate established in the agreement; subscribers who patronized non-participating pharmacies paid the pharmacies the over-the-counter prices for prescriptions, and were reimbursed by Blue Cross at the rate established in the subscriber agreement with Blue Cross.

In finding that the agreements were not *per se* violative of § 1, the district court distinguished the case before it from cases in which agreements fixing maximum prices had been struck down as unlawful. The court found that Blue Cross was in fact a bulk purchase of drugs for its subscribers; thus the agreements between Blue Cross and the participating pharmacies did not restrain the pharmacies from setting their own price for their goods and services to third parties. *Medical Arts Pharmacy v. Blue Cross & Blue Shield of Connecticut*, 518 F.Supp. 1100, 1107 (D.Ct.1981). *See Sitkin Smelting & Refining Co., Inc. v. FMC Corp.*, 575 F.2d 440, 446 (3d Cir.), *cert. denied*, 439 U.S. 866, 99 S.Ct. 191, 58 L.Ed.2d 176 (1978) (the *per se* rule applies to "an agreement to fix the price to be charged in transactions with third parties, not between the contrasting parties themselves"). On appeal, the plaintiff argued that only the Blue Cross subscriber could be viewed as the purchaser of prescriptions from participating pharmacies. In ruling that the district court properly refused to apply the *per se* standard, the Court of Appeals for the Second Circuit stated that

> even if Blue Cross cannot be characterized as the purchaser for the purpose of antitrust analysis, we consider the pharmacy agreements to be sufficiently different from the maximum price-fixing agreements struck down in *Albrecht* and *Kiefer-Stewart* to preclude application of the *per se* rule. . . . Whether Blue Cross is characterized as a purchaser or as an indemnitor or third party payor, it is the ultimate payor, and therefore its pre-

scription drug plan differs significantly from the vertical arrangements to restrict prices that [have been] invalidated.

675 F.2d at 505–6. After noting that the "pharmacy agreements are novel restraints, with potential procompetitive effects," and citing several cases and law review articles for the proposition that the *per se* rule should not be lightly applied to business relationships with a potential for enhancing competition, the court ruled that the district court properly determined that the agreements must be analyzed under the lower "rule of reason" standard. *Id.* at 505.

[13] I find the reasoning of the Second Circuit in this case to be cogent and persuasive. The restrictive agreements here challenged by the plaintiffs do not differ in substance from the agreements scrutinized in *Medical Arts Pharmacy*.[6] That the entities entering into the agreements are here doctors, as opposed to pharmacists, and that the subject matter of the agreements here involves the rendering of medical services, as opposed to the sale of prescription drugs, are distinctions without differences for purposes of determining under the antitrust laws whether Blue Shield is the "ultimate payor" of the services whose price has been fixed, and thus has the ability to restrict the price that can be received for those services. I therefore rule that the agreements here challenged by the plaintiffs should be examined under the traditional rule of reason standard to determine whether they are in violation of § 1 of the Sherman Act. *Accord: Sausalito Pharmacy, Inc. v. Blue Shield of California*, 1980–81 CCH Trade Cases 77, 722 (N.D.Cal.1980) ("*Sausalito I*"), and 1981–2 CCH Trade Cases 75, 604 (N.D.Cal.1981) ("*Sausalito II*").

[14] Both plaintiffs and Blue Shield argue in their respective memoranda in support of their summary judgment motions that they should prevail under the rule of reason analysis. This standard "requires the factfinder to determine whether, under all of the circumstances of the case, including the facts peculiar to the business and the history of, reasons for, and market impact of the restraint, the restrictive practice imposes an unreasonable restraint on competition." *Medical Arts, supra*, at 504. In light of the very limited discovery that has taken place in this case despite its four-year life-span, I rule that sufficient facts have not yet been developed to allow a proper determination under the rule of reason standard. Therefore, both plaintiffs' and Blue Shield's motions for summary judgment on this issue should be denied and an order will enter directing the parties to conduct discovery on this issue. The discovery must be completed by November 1, 1982.

V. *Conclusion*

As stated above, two of defendants' practices here challenged under the Clayton and Sherman Acts are immune from federal antitrust scrutiny. These practices are Blue Shield's refusal, with limited exceptions, to compensate non-participating physicians for medical services rendered to its subscribers, and Blue Cross' forebearance generally for the medical service insurance market inhabited by Blue Shield. Blue Shield's practice of requiring its participating physicians not to charge Blue Shield subscribers any amount over and above that which Blue Shield has previously agreed to

6. Plaintiffs claim that *Medical Arts* can be distinguished from the case before the Court because [1] the Blue Cross scheme in *Medical Arts* (unlike the Blue Shield scheme here) allowed subscribers to be at least partially remunerated for subscriptions obtained from non-participating pharmacists; and [2] that the district court judge specifically found in *Medical Arts* that Blue Cross occupied only about 9% of the relevant market, as opposed to Blue Shield's occupation of 60% or more of the relative market here. I first note that this finding by the court was made during its "rule of reason" analysis and was not mentioned by the court during its examination of the *per se* approach. 518 F.Supp. at 1103, n.9. In any event, neither of these considerations are relevant to the inquiry of whether the *per se* standard should be applied; both, of course, may be highly relevant (as they were in *Medical Arts* at both the trial and appellate stages) to the determination of whether the restrictive agreements violate the "rule of reason."

pay them on behalf of its subscribers is not exempt from antitrust challenge under either the state action doctrine or the McCarran-Ferguson Act. This Court, however, will at the appropriate time apply to this practice the "rule of reason," as opposed to the *per se* standard of antitrust analysis.

Order accordingly.

Massachusetts General Laws

Chapter 176B, § 7

§ 7. Agreement Between Corporation and Participating Physician or Chiropractor; Influencing Choice of Physician; Termination; Discrimination Against Chiropractors Prohibited.

Every registered physician and every registered chiropractor shall have the right, on complying with such rules and regulations as the corporation may make, to enter into a written agreement with a medical service corporation, doing business in the city or town where the said physician or chiropractor resides or has his usual place of business, to perform medical or chiropractic services. This chapter shall not change the normal relations between physician or chiropractor and patient. No restriction shall be placed by any such corporation upon its participating physicians or participating chiropractors as to methods of diagnosis or treatment. No officer, agent, or employee of a medical service corporation shall influence or attempt to influence a subscriber or a covered dependent in his choice of a participating physician or participating chiropractor. A subscriber or a covered dependent, subject to the bylaws, rules and regulations of a medical service corporation and the terms and provisions of his subscription certificate, shall be entitled to the benefits of this chapter upon receiving medical or chiropractic service from any participating physician or participating chiropractor or, in the discretion of the corporation, upon receiving medical or chiropractic service from any non-participating physician or chiropractor in an emergency or when outside the commonwealth. A corporation may terminate its agreement with any participating physician or participating chiropractor or any other participating provider of health services licensed under the laws of the commonwealth

at any time (a) for failure to comply with the reasonable rules and regulations of such corporation, including without limitation such rules and regulations as may be adopted governing the keeping of accounts, records and statistics, the making of reports and proof of services rendered, or (b) for presenting any fraudulent, unreasonable, or improper claim for payment, or compensation.

Nothing in section four or in this section shall be construed to prohibit any medical service corporation from entering into written agreements with its subscribers and with participating chiropractors to furnish chiropractic services to subscribers and covered dependents or from including chiropractic services in its nonprofit medical service plan, nor shall any medical service corporation discriminate in any way against participating chiropractors in the furnishing of chiropractic service to its subscribers and covered dependents. (Amended in 1978, 574, § 3, approved July 22, 1978, effective 90 days therefter; 1981, 623, § 2, approved December 11, 1981, effective 90 days thereafter.)

THE COMMONWEALTH OF MASSACHUSETTS

ADVANCE COPY 1984 ACTS AND RESOLVES

MICHAEL JOSEPH CONNOLLY, SECRETARY OF STATE

Chap. 192. AN ACT RELATIVE TO MEDICAL SERVICE CORPORATIONS.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to immediately insure the continued delivery of health services in the commonwealth, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

Be it enacted, etc., as follows:

SECTION 1. Section 7 of chapter 176B of the General Laws, as most recently amended by section 2 of chapter 623 of the acts of 1981, is hereby further amended by inserting after the first sentence the following sentence: — No participating physician or participating provider of health services shall charge to or collect from a subscriber or covered dependent any amount in excess of the amount of compensation determined and allowed by a medical service corporation pursuant to the applicable method of compensation approved by the commissioner, except when such subscriber or covered dependent (*a*) is eligible for benefits under a subscription certificate containing a provision permitting such charge or collection when the subscriber or covered dependent (*i*) is entitled to receive reimbursement or compensation from a third party for the cost of the same or similar services or (*ii*) receives money

or its equivalent as a result of a claim against a third party for loss or damages for personal injuries, and only in the circumstances and to the extent so permitted, or (*b*) is eligible for benefits under a subscription certificate which provides for compensation to a participating physician or other participating provider of health services under a nonprofit medical service plan previously approved by the commissioner, the so-called "Plan B", and has an annual income in excess of seven thousand five hundred dollars, or (*c*) is eligible for benefits under a subscription certificate under a group medical service agreement containing a provision describing the specific circumstances under which and the extent to which additional amounts may be charged or collected; provided, however, that such provision has first been approved in writing by the commissioner and has been requested by the employer, employers or other representatives of the group to which it applies, and only in the circumstances and to the extent so described.

SECTION 2. A special commission to consist of six members of the Senate, eleven members of the House of Representatives, the Secretary of Consumer Affairs and Business Regulations or his designee, the President of the Massachusetts Medical Society or his designee, and four persons to be appointed by the Governor, one of whom shall be a representative of Blue Shield of Massachusetts, one of whom shall be a representative of Blue Cross of Massachusetts, one of whom shall be a representative of the Life Insurance Association of Massachusetts, one of whom shall be a representative of organized labor. The special commission is hereby established to make an investigation and study of the laws relating to nonprofit hospital services corporations and nonprofit medical services corporations, as established pursuant to chapters one hundred and seventy-six A and one hundred and seventy-six B of the General Laws. Said commission shall, in the course of its investigation and

study, consider, among other questions it deems relevant, the tax, reimbursement and regulatory status of said corporations in Massachusetts, their standing in relationship to other health care insurers and nonprofit medical services corporations within and without the Commonwealth, to government programs of health insurance, and to competing and alternate forms of health care financing. Particular attention shall be paid to the corporations' rights to contract with professional an other noninstitutional providers of health care services, the system of payments made by said corporation, including the impact of the prohibition on the practice of balance billing, so-called, the financial and accounting procedures of said corporations and their impact on the quality and cost of health care services.

Said commission may expend for expenses and for legal, actuarial, research, clerical and other assistance such sums as may be appropriated, therefor, not to exceed two hundred thousand dollars annually; provided, however, that all costs of administration and operation of said commission shall be borne by nonprofit hospital service corporations established pursuant to chapter one hundred seventy-six A of the General Laws, nonprofit medical service corporations established pursuant to chapter one hundred and seventy-six B of the General Laws, the Massachusetts Medical Society, and the Life Insurance Association of Massachusetts. The secretary of the office of consumer affairs and business regulations shall apportion the estimated costs of said commission on said organizations on a fair and reasonable basis. Said estimated costs shall be paid to said secretary within thirty days after notice from said secretary of such estimated costs. Said secretary shall subsequently apportion actual costs among all said organizations and shall make assessment adjustments for the same for any variation between estimated and actual costs on a fair and reasonable basis. Such estimated and actual costs shall include an amount equal to the cost of fringe benefits as established by

the commissioner of administration pursuant to section six B of chapter twenty-nine of the General Laws.

Said commission shall meet at least quarterly, may report from time to time to the general court, and shall file the results of its investigation and study, and its recommendation, if any, together with drafts of legislation necessary to carry its recommendations into effect with the clerk of the house of representatives in its first annual report no later than July first, nineteen hundred and eighty-five, and shall file its final report on or before December thirty-first, nineteen hundred and eighty-five.

Approved July 12, 1984.

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Nos. 84-1353, 84-1354

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1984

JAMES P. KARTELL, et al.,
Petitioners,
v.
BLUE SHIELD OF MASSACHUSETTS, INC., et al.,
Respondents.

GRANT V. RODKEY, et al.,
Petitioners,
v.
BLUE SHIELD OF MASSACHUSETTS, INC., et al.,
Respondents.

On Petitions for Writs of Certiorari to the United States Court of Appeals for the First Circuit

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BRIEF IN OPPOSITION OF THE RESPONDENT MASSACHUSETTS COMMISSIONER OF INSURANCE

FRANCIS X. BELLOTTI
ATTORNEY GENERAL

H. Reed Witherby
Counsel of Record
Assistant Attorney General
Government Bureau
One Ashburton Place, Room 2019
Boston, Massachusetts 02108
(617) 727-1020

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QUESTION PRESENTED

Is it a violation of the Sherman Act, § 1, for a state-regulated medical insurance company to enter into agreements with individual doctors in which the doctor agrees to a prohibition, now imposed directly by Massachusetts statute, against charging insured patients any additional amount above and beyond what the insurance company has paid to the doctor for a covered service?

PARTIES

This Brief in Opposition is submitted on behalf of the Massachusetts Commissioner of Insurance, who intervened as a defendant in the district court and was an appellant in the court of appeals. The Commissioner did not receive the petitions until March 1, 1985.

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On Petitions for Writs of
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First Circuit

BRIEF IN OPPOSITION OF THE RESPONDENT MASSACHUSETTS COMMISSIONER OF INSURANCE

The Massachusetts Commissioner of Insurance ("Commissioner") adopts the statements of "Opinions Below" and

"Pertinent Statutes" of the Brief in Opposition of the respondent Blue Shield of Massachusetts, Inc. ("Blue Shield").

STATEMENT OF THE CASE

To Blue Shield's "Statement of the Case," the Commissioner adds:

Blue Shield is a non-profit medical service corporation organized under Mass. Gen. Laws Ann. ch. 176B for the statutory purpose of providing low-cost medical insurance coverage to the Massachusetts public. See Massachusetts Medical Service v. Commissioner of Insurance, 344 Mass. 335, 337-38, 182 N.E.2d 298, 300-01 (1962). It is the only entity in the Commonwealth organized and operating under Chapter 176B, which "establishes a comprehensive scheme for the public

supervision of medical service corporations." Nelson v. Blue Shield of Massachusetts, Inc., 377 Mass. 746, 750, 387 N.E.2d 589, 592 (1979):

> The Commissioner must approve Blue Shield's articles of organization (§ 2), its by-laws (§ 3), the form of its agreements with participating providers and its methods of compensating them (§ 4), its subscription certificates and the rates it charges subscribers (§§ 4, 6). He has free access to its records, may examine its employees as to its affairs, and may prescribe the manner in which its records are kept (§ 9). He may enforce the provisions of the statute through judicial proceedings (§§ 13, 17). Moreover, § 12 provides for administrative decision, subject to judicial review, of any dispute between Blue Shield and a participating physician, or between Blue Shield and a subscriber.

Id. In exercising his regulatory authority, the Commissioner has sought to guard against excessive physicians' costs to Blue Shield subscribers, in support of

the public policy underlying ch. 176B of health care cost containment.

The "ban on balance billing," which was challenged by the petitioners in this case, and which provides that participating doctors may not charge their patients who are Blue Shield subscribers any additional amounts above and beyond what Blue Shield pays to the doctor for a covered service, has long been part of the Blue Shield reimbursement system established under Mass. Gen. Laws Ann. ch. 176B. Kartell v. Blue Shield of Massachusetts, Inc., 384 Mass. 409, 414-18, 425 N.E.2d 313, 316-18 (1981). The Commissioner has not merely approved this provision in the course of his supervision of Blue Shield; in 1976 and 1977, shortly before the commencement of this litigation, he rebuffed a proposal to

relax it.[1] The Commissioner intervened as a defendant in 1979 to assert its lawfulness by virtue of the state action doctrine and of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015.[2]

The district court's decision striking down the ban on balance billing, Kartell v. Blue Shield of Massachusetts, Inc., 582 F. Supp. 734 (D. Mass. 1984) (Pet. A28), appeared likely to have a

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1/ See ¶ 37 of the Stipulation of Facts appearing at pp. 96-97 of the joint appendix in the Court of Appeals; Kartell, supra, 384 Mass. at 421, 425 N.E.2d at 320 (referring to the Commissioner's compulsion of the ban since 1968).

2/ These arguments were rejected in Kartell v. Blue Shield of Massachusetts, Inc., 542 F. Supp. 782 (D. Mass. 1982). The district court's rationale for rejecting the state action argument -- that statutory compulsion was lacking, id. at 788 -- has now been rejected by this Court in Southern Motor Carriers Rate Conference, Inc. v. United States, No. 82-1922 (March 27, 1985).

dramatic effect upon the consumers of physicians' services in Massachusetts, in light of the substantial potential increases in health care costs to Blue Shield subscribers. The Governor of the Commonwealth of Massachusetts promptly introduced corrective legislation, advising the legislature that:

> The legislation accompanying this message is filed in response to a recent decision by the United States District Court for the District of Massachusetts relating to Blue Shield of Massachusetts. The court has ruled that Blue Shield's ban on balance billing is precluded by the federal antitrust laws in the absence of a clear expression of state policy requiring it. Because the District Court does not believe that a sufficient expression of state policy exists, corrective legislation is required to supply it.

Mass. House Doc. No. 5624 (April 6, 1984). The Legislature thereafter

passed and on July 12, 1984, the Governor signed Mass. St. 1984, c. 192, which adds the following language to Mass. Gen. Laws Ann. ch. 176B, § 7:

> No participating physician or other participating provider of health services shall charge to or collect from a subscriber or covered dependent any amount in excess of the amount of compensation determined and allowed by a medical services corporation pursuant to the applicable method of compensation approved by the commisioner, [with certain defined exceptions].

St. 1984, c. 192, § 1.[3/]

The Commissioner and Blue Shield, whose appeals were then pending in the First Circuit, both moved to vacate the district court's decision and to dismiss the Amended Complaint on the basis that the new statute clearly immunized the

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3/ The full text is reproduced in Blue Shield's Brief in Opposition at 38a-41a.

ban on state action grounds and rendered the merits moot, since only injunctive relief was sought by the Amended Complaint. The court of appeals did not reject this argument; instead, in light of a related pending damages complaint, and because decision of the merits would resolve all the pending claims in this protracted litigation, the court of appeals chose simply to proceed directly to the merits. Kartell v. Blue Shield of Massachusetts, Inc., 749 F.2d 922, 924 (1st Cir. 1984) (Pet. A5).[4/]

4/ Ignoring the court's clear statement to the contrary, id., the petitioners in No. 84-1354 say that the First Circuit "plainly rejected" this argument, because mootness goes to Art. III jurisdiction. Reply Brief in Support of Petition ("Reply Brief") at 3-4. The point of the Commissioner's motion, of course, was not that the case was moot, but that the merits need not be reached in light of state action immunity.

SUMMARY OF ARGUMENT

The Commissioner fully supports the argument in Blue Shield's Brief in Opposition that these petitions should be denied because the decision of the court of appeals is in harmony with decisions of this Court, recent decisions of four other courts of appeals, and the weight of scholarly comment. The Commissioner writes separately to emphasize the impact of Mass. St. 1984, c. 192, particularly in light of this Court's recent decision in Southern Motor Carriers Rate Conference, Inc. v. United States, No. 82-1922 (March 27, 1985).

The enactment of Mass. St. 1984, c. 192 removed any doubt about the immunity of the ban on balance billing under the state action doctrine. Moreover,

Southern Motor Carriers now makes clear that even without the new state law, the ban on balance billing was entitled to state action immunity. The petitions should be denied because any reversal of the court of appeals' determination of the merits (which was correct in any event) would not, in light of state action immunity, change the result in this case.

ARGUMENT

REVIEW OF THE MERITS WOULD BE OF NO PRACTICAL SIGNIFICANCE IN THIS CASE BECAUSE THE STATE ACTION DOCTRINE CLEARLY REQUIRES THE SAME RESULT.

Prior to the enactment of Mass. St. 1984, c. 192, doubt may have existed as to whether the ban on balance billing was immune under the state action doctrine. The district court had held that

in the absence of compulsion by the state legislature the ban on balance billing could not qualify for state action immunity. Kartell v. Blue Shield of Massachusetts, Inc., 542 F. Supp. 782, 788 (D. Mass. 1982). The appeals which were pending in July 1984 presented issues concerning the analysis and application to this case of the state action doctrine. These arguments were rendered moot by the passage of Mass. St. 1984, c. 192.

A. The Statutory Prohibition of Balance Billing by c. 192 is Clearly the Action of the State.

As the direct and explicit command of the Massachusetts Legislature, the statutory prohibition of balance billing is clearly the action of the State

within the meaning of the state action doctrine.

This Court held in Parker v. Brown, 317 U.S. 341 (1943), that Congress in enacting the Sherman Act did not intend to restrain "state action." Id. at 351. In adopting the program there challenged, the state, "as sovereign, imposed the restraint as an act of government which the Sherman Act did not intend to prohibit." Id. at 352. Last term, this Court reaffirmed that "under this Court's rationale in Parker, when a State Legislature adopts legislation, its actions constitute those of the State, see [317 U.S.] at 351, and ipso facto are exempt from the operation of the antitrust laws." Hoover v. Ronwin, 467 U.S. ___, 104 S. Ct. 1989, 1995 (1984). See also New Motor Vehicle Board of California v.

Orrin W. Fox Co., 439 U.S. 96, 109 (1978). Since the ban on balance billing is now an express statutory provision, nothing further is required to demonstrate state action immunity.[5/]

The tests of California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., 445 U.S. 97 (1980), are intended in appropriate cases to assure that action claimed to be that of the state is indeed so attributable. Since the new state law is undeniably the action of the state, there is no need to conduct

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5/ The Reply Brief at 5, n. 6 argues that the statute is preempted by 29 U.S.C. § 1144(a). Even if it did "relate to" employee benefit plans (which it does not), ch. 176B, including this amendment, clearly is a law "regulating insurance" under 29 U.S.C. § 1144(b)(2)(A). Cf. Metropolitan Life Insurance Co. v. Massachusetts, No. 84-325 (argued Feb. 26, 1985).

any inquiry under Midcal. "Where the conduct at issue is in fact that of the state legislature . . ., we need not address the issues of 'clear articulation' and 'active supervision.'" Hoover, supra, 104 S. Ct. at 1996. Chapter 192 does not operate indirectly through a state representative or a private party; by its express terms, it operates as a direct prohibition upon participating physicians themselves.

In any event, the Legislature's intent to prohibit balance billing of Blue Shield subscribers could hardly have been articulated more clearly or expressed more emphatically. See p. 7, above (quoting St. 1984, c. 192).[6/] Such

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6/ The state policy unmistakeably established by St. 1984, c. 192, § 1 is no

(footnote continued)

direct and specific legislative compulsion often is the best evidence of a clearly articulated and affirmatively expressed state policy. See Southern Motor Carriers, supra, slip. op. at 13.

Moreover, the statute was enacted in direct response to a judicial determination that the conduct which it requires is otherwise a violation of the Sherman Act, and it was clearly intended to countermand that result -- dramatic evidence of legislative intent to invoke the state action doctrine. The federalism concerns

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(footnote continued)

less clear because of its three precisely-defined statutory exceptions. Contra, Reply Brief at 4. The petitioners ignore the practical realities which both counsel and limit the scope of those exceptions and, with respect to the third exception, the express requirement of the Commissioner's prior approval.

underlying the state action doctrine should apply most strongly under such circumstances.[7/]

B. This Court's Recent Decision in Southern Motor Carriers Confirms the State Action Immunity of the Ban Even Without the New State Law.

This Court has just held that: (1) compulsion is not an essential ingredient of state action immunity, Southern Motor Carriers, supra, slip op. at 11; (2) a

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7/ Although the express statutory prohibition obviates the need for a supervision inquiry, which serves essentially the evidentiary function of ensuring that the actor is engaging in the challenged conduct pursuant to state policy, Town of Hallie v. City of Eau Claire, No. 82-1832 (March 27, 1985), slip op. at 10-11, it may be noted that c. 192, § 2 provides for a specific state inquiry into the ban on balance billing, above and beyond the Commissioner's regular oversight. See Blue Shield's Opposition at 40a.

"private party acting pursuant to an anticompetitive regulatory program need not 'point to a specific, detailed legislative authorization' for its challenged conduct," id. at 15; and (3) no showing of necessity is required for invocation of the state action doctrine, id. at 9, n. 21. These holdings make clear that, even before the passage of St. 1984, c. 192, the ban on balance billing was entitled to state action immunity.

The court of appeals correctly found that "the price system here at issue is one supervised by state regulators." Pet. A19. Blue Shield is a regulated private party, see pp. 2-4 above, and Mass. Gen. Laws Ann. ch. 176B always has contemplated the permissibility of the ban on balance billing. Kartell v. Blue

Shield of Massachusetts, Inc., 384 Mass. 409, 422-23, 425 N.E.2d 313, 320-21 (1981); Nelson v. Blue Shield of Massachusetts, Inc., 377 Mass. 746, 750, 387 N.E.2d 589, 592 (1979).

The petitioners argue that active state supervision is lacking because the Commissioner does not set fees for specific physician services. Petition in No. 84-1353, at 17 & n. 16; Reply Brief at 5, n. 5.[8/]

The Commissioner exercises instead the statutory responsibility of approving the methodology by which the amounts of physician payments by Blue Shield are

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8/ Contrary to the assertion of the Reply Brief at 5, no court has yet analyzed the satisfaction in this case of the second prong of the Midcal test.

determined.[9] Perhaps more important, the Commissioner is charged with reviewing the reasonableness of Blue Shield's rates to subscribers, in which the availability or not of balance billing, as well as the amounts of physician costs to Blue Shield, are integral considerations.

Moreover, the petitioners' emphasis upon the lack of state-established fee schedules confuses what is at issue in this case. The petitioners did not challenge, and the district court did not enjoin, the usual and customary method-

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9/ The selective quotation in Reply Brief at 5, n. 5 is misleading in this respect. The statute prohibits the charging of "any amount in excess of the amount of compensation determined and allowed by a medical service corporation pursuant to the applicable method of compensation approved by the commissioner . . .." (emphasis added).

ology,[10/] but the ban on balance billing. "The issue before the Court in this case is whether Blue Shield's ban on balance billing constitutes a restraint of trade . . .." Pet. A40 (emphasis added). "I rule that defendants' ban on balance billing imposes an unreasonable restraint . . .." Pet. A67 (emphasis added).

Since the ban on balance billing is clearly imposed by the state, as sovereign, as an act of government, a review of the decision of the court of appeals

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10/ As the petitioners in No. 84-1354 stressed in the court of appeals:

> Plaintiffs agree that defendants, like any other health insurer, are entitled to say to providers of service, "This is what we will reimburse you for specific services."

Intervenor-Plaintiffs' typed Brief dated July 20, 1984, Part I(A), at 22.

on the merits would serve no practical purpose to the resolution of this case.[11]

11/ The petitioners in No. 84-1354 seek rescue from this conclusion in a separate complaint for past damages. Reply Brief at 6. In light of Southern Motor Carriers' favorable implications for the state action defense for the period prior to the enactment of St. 1984, c. 192, this argument has little force. Moreover, that complaint is a dead letter under standard principles of preclusion against claim-splitting. See Restatement (Second) of Judgments, §§ 24, 25. The petitioners could have preserved a damages claim only by renewing, on cross-appeal from the final judgment, the claims they sought to raise in Kartell v. Blue Shield of Massachusetts, Inc., 687 F.2d 543 (1st Cir. 1982).

CONCLUSION

The petitions for writs of certiorari should be denied.

Respectfully submitted,

FRANCIS X. BELLOTTI
ATTORNEY GENERAL

H. Reed Witherby
Assistant Attorney General
Counsel of Record
Government Bureau
One Ashburton Place, Room 2019
Boston, Massachusetts 02108
(617) 727-1020

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